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Fundamental contradiction

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Mavis Kirkham explains why the business model does not fit midwifery values

Midwifery is beset with problems at present and, as we seek to deal with each crisis, there is no time to look at the source of the problems. As I am a retired academic and no longer practicing, thanks to a set-to with our statutory body which I will not go into, I have time and feel the need to stand back a bit and to look at this.

It seems to me that there is a clash of values. Midwifery is rooted in relationships and a tradition of generosity, which research and long experience has shown to have excellent clinical and social outcomes. Most women can birth well if they are surrounded by people who value them, listen to them and nurture their self-confidence. The NHS is now run on a commercial model: the imperative being to get more for less input. In industrial terms this is called efficiency: maximum productivity for minimum cost. In any other context it is seen as meanness.

Centralisation

Maternity services have been centralised into large hospitals. Applying principles seen as 'sound' in business terms, units have been closed which would have been seen as large ten years ago. Centralisation produces economies of scale or more output for less input and in maternity care the main input is staffing. So midwives are part of a large body of staff who can be moved wherever they are needed and the traditional ebb and flow of smaller scale units is ironed out to a situation where staff permanently feel they are working flat out. This is reputed to be a very efficient way to run a factory based on a production line; but we are dealing with people.

So many studies have shown that women feel they are on a conveyor belt, which they see as synonymous with not being treated as a human being. Midwives feel they are treated as a cog in a machine and not as people. Midwives value relationships with their clients and with colleagues, so that trust can develop and the bigger the unit and the more staff are moved about the more relationships are fragmented. So trust does not develop and fear flourishes in the absence of trust.

Control and standardisation

If a large organisation is to be run for maximum efficiency management control is required to monitor and ensure that efficiency. Midwives cannot be trusted to do midwifery or to decide a woman's care in response to her needs as this might lead to care being given beyond the 'efficient' norm. Thus

standardisation is required.

Standardisation requires care to be defined as a series of tasks which can be monitored rather than a continuing supportive relationship. If the required tasks are performed then women can logically be neglected between tasks and the midwife's attention given to other women, even when they are feeling most vulnerable in labour. Defining labour care as a series of standardised tasks makes it possible to give midwives such heavy workloads that they cannot give individualised care, especially as such care is required to be thoroughly, time-consumingly justified. Standardisation is justified as preventing really bad care but it also prevents really good care from being the norm; though many midwives strive to give good care, often at great cost to themselves. This approach is often described as being evidence-based, but research deals with the general, never stating what an individual needs and much evidence is based on a consensus of those thoroughly versed in cost-saving.

Ironically, a considerable bureaucracy is needed to monitor the efficiency of a large organisation, so costs rise, which leads to further cuts to keep costs under control. Such cuts are seldom due to the bureaucracy, which is seen as essential.

Staffing

These pressures damage midwives, as individuals and as a workforce. We have plenty of research on this. Lack of occupational autonomy distresses midwives.[1] Midwives leave because they cannot give the care they would wish to give,[2],[3] which leads to less staff which puts further pressure on those who remain and this leads others to leave. As this vicious circle produces job vacancies, the opportunity is often taken to reduce jobs and thereby save resources. Outside London, I am not sure whether the problem is a shortage of midwives or a shortage of midwifery posts.

With increasing financial pressures, specialist posts are cut back. This removes midwives who have found their niche and built up expertise and a degree of autonomy in a specialist role and moves them back onto the conveyor belt where they are more likely to leave.[4] It also reduces the help available to mothers.

Commodification and technology

The commercial model is about selling products. With the pressures of cuts to the NHS, this means that parts of the service which can be identified become separate products. Thus NHS antenatal classes in many places have been cut to the extent that women have to pay for them outside the NHS. 'Special' antenatal classes, such as hypnobirthing, often have to be paid for. NHS midwives cannot give continuing support to childbearing women, so they employ doulas. Breastfeeding support is available, at a price.

This commodification of what was once seen as midwifery care provides a safe, if commercially vulnerable, haven for a few midwives and other workers. But it discriminates heavily against those who cannot afford the extras. It also prevents integration of services and continuity of carer.

On a larger scale, there are massive pressures from the producers of technical products. We still use

electronic
fetal heart monitors in many circumstances where research has shown they do not help and may hinder women in labour. Commercial pressures and the value our society places upon technology have created a real fear of not using all the technology available. Yet this can have damaging results for individuals and can greatly increase costs, as with increased caesarean rates with EFM,[5] and that money has to be saved elsewhere.

The status which comes with technology may be one reason why midwives have embraced so many additional, technical tasks over the years. Thus a cloak of technology is cast over a very basic human service and midwives come to be seen as skilled technicians who are 'checking not listening'[6] to women. We cannot do everything, though we try hard, and basic supportive care fades in significance or moves into the role of the doula or support worker. Thus we neglect what research shows works best.

Insurance

Insurance is probably the ultimate example of a product so well marketed that it appears unethical not to have it. Yet its main beneficiaries are the insurance companies. Once insurance is required for practitioners, the insurance companies can control clinical practice. In the USA, managed care is packaged and defined by insurance companies. In this country the conditions of insurance determine who can receive care from independent midwives, thus excluding many women who seek independent midwives because they find themselves damaged by previous NHS care. And, if regulators decide that insurance is insufficient, care can be removed from women as happened here recently.[7]

Above all, this system is unjust. If a child needs special care, that care should be available because the child needs it, not if it can be funded because someone can be blamed. No fault compensation works in New Zealand. New Zealand midwives do not understand the problems with insurance here because, once liability for the care of a child is removed, the cost of clinical negligence insurance is manageable for them.

As well as being unjust, insurance is horrendously expensive, accounting for a high proportion of the cost of each NHS birth. How can clinicians provide an economic service if they have to carry this massive cost?

Midwifery values

Midwifery is grounded in relationships and works best where midwives have trusting relationships with clients and colleagues. To achieve this we need a degree of professional autonomy and continuity in our relationships with clients and colleagues. Present values of fragmentation and management control thwart these relationships. Midwives' professional commitments to their clients simply leads to their exploitation in the context of commercial values. This is shown where so many work extra unpaid hours rather than abandon vulnerable women.

Trapped in this contradiction between their professional values and those of their employers, NHS midwives are torn apart. They continue trying to do the impossible. Their leaders speak the rhetoric of

midwifery while clinical midwives work within the reality of a service aiming for maximum efficiency. They see the needs of the clients but their workload is such that they cannot respond to these needs. This is not a healthy way to live. It damages midwives, makes the most rewarding job in the world highly frustrating and is not acknowledged as a problem.

Care and its impact

Midwifery is a public service which can have a long term impact on the lives of families. This is achieved through care – showing how to change a nappy or modelling for women who have only interacted with adults, the ways in which they can relate to a tiny, totally dependent baby, or just providing approval and safe space for them to get to know their babies. In Meg Taylor's words:
'...the midwife metaphorically holds the mother so she can both literally and metaphorically hold her baby. It is obvious that when women are in labour they need a high level of care and attention, but I think a particular quality of attention continues to be required in the postnatal period ... [thus] ... providing this kind of holding.'[8]

In providing such holding, the midwife models the generous, loving care which makes its recipient feel safe. This crucial holding is not possible where care is fragmented, labour care is divided into a series of monitoring tasks and postnatal support is minimised and thereby seen as efficient. Where care is fragmented, the midwife's attention is on the task in hand not the individual mother and the long term value of the midwife- mother relationship can be lost.

If midwives are to model trusting relationships and provide empathetic care, they need to receive such care themselves and be trusted in their role. This is not the experience of most NHS midwives and may become less likely as we lose the role of supervisor of midwives.

The future

Tight control and penny pinching may work in business, though some experts dispute this, but a different ethic is required for public services.[9] Addressing only short term, easily measurable outcomes is not a commitment to the next generation.

A society based on commercial values neglects care at its peril. This can be seen in many areas of life[10],[11] but nowhere is this clearer than at the beginning of life. This is especially clear as birth is something that most women can do supremely well if they are trusted and supported and a good start in life has positive outcomes throughout the life of a family.

Nursing and Midwifery Council
Is it time for a General Midwifery Council?

Criticisms of the NMC continue to grow, and have now reached a level where Jeremy Hunt has ordered an inquiry into the actions of the NMC following the Morecambe Bay disasters

where 16 babies and three mothers died. An inquiry is long overdue, but should not be restricted to Morecambe Bay; the NMC's activities over the years have been a constant source of criticism.

In order for midwives to practice safely and successfully they need a governing body that prioritises the interests and safety of mother, baby and maintains the standards of midwifery practice. Until recently the Midwifery Committee of the NMC played a large part in guiding the NMC in this process. Unfortunately, over the years the strength of the Midwifery Committee has been eroded to the point where it has become little more than a cypher and despite the fact that its existence has been guaranteed by statute there are plans to abolish it.

In 1983 the Central Midwives Board was absorbed into the UK Central Council for Nursing, Midwifery, and Health Visiting (later the NMC) and, as a sop to those who protested the move, it was agreed that a Midwifery Committee would be established within the NMC to advise the Council on all matters affecting midwifery. The initial committee had over 20 members, predominately midwives, and over the years reduced to seven members, only one of them was a midwife, and she was not in practice. The plan is to replace the Midwifery Committee and instead have a 'Panel' advising the NMC Chief Executive, and a single midwife on the Nursing and Midwifery Council.

Donna Ockenden has been appointed as senior midwifery advisor to the chief executive, but no matter how determined Donna might be she will be a single voice for the whole of midwifery and, unlike the Midwifery Committee which was established by statute, the NMC has no requirement to pay any attention, whatsoever, to what she says. Furthermore, few Trust Boards have a senior midwifery presence, nor does NHS England.

If the NMC plans go ahead unchallenged there will not be a midwifery profession because of the NMC's lack of awareness, and understanding, of midwifery as an autonomous profession. If women and babies are to be protected then the time has come to establish a General Midwifery Council to properly serve the interests and safety, of women, babies, and midwives.

Beverley A Lawrence Beech

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As a result of the NMC's claim that Independent Midwives did not have sufficient insurance, and its refusal to indicate what would be sufficient, Independent Midwives UK has served notice to apply for a judicial review. This is an expensive process, and not available to most midwives who want to challenge NMC decisions, so they are crowd funding. See www.gofundme.com/Independent- Midwifery-Fighting-Fund.

Alongside the contradiction between the values of business and those of midwifery lies the further irony

that, for most women, midwifery care has excellent outcomes and may well be cheaper than heavily managed hospital care.[12]

In supporting normal birth, working in primary health and strengthening family ties,[13] midwifery provides a sustainable service and can be seen as a '*truly ecological and socially responsible profession*'.[14] (Davies et al 2011 p2).Yet so much that midwives are required to do flies in the face of this. We hear midwives being criticised because they lack resilience. I think it is far more useful to see our current dilemmas as manifestations of a fundamental clash of values and the logic which follows from those values, rather than blaming the individuals who suffer these contradictions. The logic of business and the logic of caring represent a fundamental contradiction that lies at the very heart of our maternity services.

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More information is available from Association of Radical Midwives – because midwifery matters! www.midwifery.org.uk #savethemidwife

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