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Failures in Maternity System Regulation

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By Beth Whitehead

After a difficult birth, it is natural to feel overwhelmed and exhausted. What I found the toughest part to deal with was my experience of abuse at the hands of healthcare staff, as well as the sense that they should not have treated and spoken to me the way they did, in their professional positions. I tried hard to push these feelings aside, at times I even tried to justify them as people liked to say they were just doing their jobs. They were not. Their job was to support, listen to, care and protect me but that was not what they did. They assaulted my body, caused severe mental and physical injuries and insulted me with degrading comments.

I did not want what happened to me to happen to other women, which was why I made a complaint. As I spoke to other women with similar experiences, I found that they decided to complain for the same reason. While sharing our frustrations of how poorly our complaints were dealt with, we soon realised we were also uncovering a system protecting the healthcare staff, our abusers. We need to put the regulatory bodies that are supposed to protect us under the microscope to understand what is failing and compromising safety for women and babies.

The effectiveness of a regulator or the profession it is regulating is reflected by how well they deal with complaints i.e. when things go wrong or when professionals break codes of conduct. In the case of healthcare or maternity services, it is also a reflection of safety and how well the profession practices in respect of human rights laws. I will examine each of the common issues or systemic inadequacies I and many women have encountered in the complaints process.

Power Imbalance

Despite the legal requirement on informed consent, it is not always possible to prove its violation on paper because what is written by healthcare providers in a woman's maternity notes (a legal document) can be different to what actually happened and her experience. Furthermore, the maternity notes are often considered to be "expert opinion" and more credible evidence than a woman's own account of what happened.

The hospital setup is fragmented, with women being pushed from triage to the assessment room, then labour ward or birth centre, meeting various staff for the first time who have no knowledge of their

clinical history nor understanding of their birthing decisions. These are examples of the structural power imbalance in place that disempowers women from the start. However, this is just the tip of the iceberg.

Dismissive Attitude

When I, and many others, complained to the hospitals about maternity services, the standard replies were denial and a minimisation of our experience, pathologising pregnancy and birth (including addressing women as patients). The harm or injuries caused by their staff's interference and negligence are framed as faults of our bodies, dismissing abuses as one-off events rather than acknowledging wrong-doing, improving practices and safety. It is a systemic issue. Institutionalised obstetric violence against women has been reported in a national newspaper recently.[1] Women who have experienced harm, and their birthing partners (including birth workers) who have witnessed abusive practices, need to speak up and speak out about what happened behind closed doors.

Complaints about midwives are considered on an individual basis by their regulator, the Nursing and Midwifery Council (NMC). This means if you have experienced abuse from three midwives at your birth, the combined compounding effects of all their actions are not acknowledged and the obvious cultural issue in the team is also not dealt with. This means your complaint is structurally minimised and made easier to dismiss as each midwife's words and actions are considered individually.

Failures of Fitness to Practise

The NMC is tasked with investigating complaints of midwives in the interest of public safety. It has a process to assess 'fitness to practise'. However, in complaint responses, I have seen assessments of midwives' fitness to practise used to dismiss abuses carried out by them as one-off events that somehow the NMC believed will not happen again. Other complaints were found not to meet their "seriousness" threshold, even when they were obvious incidents of assaults.

What does this actually mean? What I can see is the NMC's unwillingness to acknowledge and address registered midwives' abusive behaviours. Abusing a person once can cause substantial lasting damage to them and their babies. The baseline should be that abuses should not happen, NOT EVEN ONCE! There should be NO free passes to abuse handed out to midwives by their regulators and employers. A person cannot attack another person on the street and claim it as their first offence to justify dismissal. Laws that apply outside of the birth rooms should also be applied inside them. No excuses and no exclusions.

Fitness to Practise is ineffective. Complaints go through a screening process where care quality or the impact of abusive practices on women are often dismissed as insufficiently serious. The NMC's definition of "seriousness" is vague and subject to their own biases. In a complaint investigation report from May 2019 that was shared with me, the NMC Case Midwife defended the hospital practices and dismissed the woman's concerns even though there was repeated evidence of violation of human rights in the hospital midwives' conduct. For example, coercion for vaginal examination, withdrawal of pain relief, verbal abuse, physical assault – a midwife carried out a dangerous, controlling and damaging manoeuvre (to restrain the woman) that was not in the midwifery curriculum. It is horrifying to see, in writing, the

NMC's support for midwives who abused and assaulted women - the violence and the severe injuries caused.

Failure to Protect Women

The problem with 'Fitness to Practise' is that it focuses on the future practice of the midwife, i.e. how they will practise AFTER the incident that led to the complaint. The underlying assumption that the NMC makes is that if the offender appears remorseful, they will not abuse women again. They even said the NMC "is not about punishing people for past events". It is like saying if a rapist says they are sorry and will not rape again, they are set free.

Where does this leave women who have been abused? It means no acknowledgement for the abuse carried out by the midwives against the woman and a continued culture of no accountability. In the investigation report, I could see the Trust knew how this worked and provided scripts to keep the NMC satisfied without being called into further investigation or requests for policy changes.

Lack of Respect for Women's Rights

Another thing that stood out in the NMC investigation report that I read was the lack of respect for a woman's right to decide her place of birth, to decline tests, assessments and interventions. They also did not recognise and acknowledge coercion which was carried out by midwives in violation of human rights. This is troubling because when a regulator fails to defend women's rights, it is not doing its job in holding its registered midwives accountable to their professional requirements: advocating for women's rights and supporting them in their maternity journeys with kindness and compassion.

Lack of Independence and Oversight

The Professional Standards Authority (PSA, www.professionalstandards.org.uk) is meant to be an independent organisation overseeing the NMC. It conducts performance reviews of the NMC but cannot intervene in the NMC's decisions about individual cases. There is no external body that can intervene in the NMC's case work. In other words, there is no mechanism in place to ensure informed consent and respectful care is being practised. Consequently, there is no real culture of accountability in the maternity system.

In fact, the NMC's own fitness as an organisation and regulator has been called into question time and time again[2,3,4]. Sadly, it appears little has changed in practice since the PSA's Morecambe Bay report[2] was published in May 2018. When a regulator minimises and dismisses women's experience of abuse by midwives, defends the abusers and the abuses, it is not just victimising and mentally abusing the victims but also enabling abuses. Fish rots from the head.

The Public Health Services Ombudsman (PHSO, the Ombudsman) is supposed to be an independent complaints investigator, but it will only take cases after women have gone through the complaints

process with the hospitals. This not only gives the maternity units the opportunity to deny the woman's experience and defend their actions, but also alert them to close the ranks, cover up evidence of abuse. The Ombudsman also applies a strict time limit of one year from the incident – so the date of birth of the baby - for women to file complaints. Many women who have been abused by hospital staff find this timeline difficult to meet. This is because they are often still traumatised, riddled with anxiety in dealing with the health system or their abusers, struggling with caring for their babies, self-recovery or mental health issues caused by the birth abuses.

What about the police? I reported the birth rapes and assaults I experienced to the police but they dismissed my complaints and defended the hospital staff despite the extent of the violence and human rights violations. This was not from lack of evidence or seriousness of the offence, but because they believed that what a healthcare provider does must be necessary, and because they did not recognise that women's rights to their own body do not cease when they are pregnant or go into labour. The law must evolve to recognise obstetric violence as a punishable offence in order for practices and healthcare culture to improve. This is happening, but too slowly.

What Needs to be Done

Our government needs to be serious about protecting women's safety and our rights when accessing the maternity system. What is clear is that what happened to us - the abuses and failures by healthcare providers, regulators and police - were not just isolated incidents but consistent systemic failure. What we need is an urgent parliamentary investigation into the effectiveness, usefulness and independence of regulatory organisations, especially the NMC, which are failing women and families, and enabling abuses to carry on. Failure of the regulator is failure of a maternity system. It needs fixing.

Despite its current ineffectiveness, I urge everyone who has experienced violence of any form and degree, verbal, physical, mental, emotional or psychological, at the hands of midwives, when feeling able to, to continue to report to the NMC. If we do not report, we do not have evidence of abuses and the regulators' failure. We should not be silenced or gaslighted, for the way to stop abuses is by speaking up, comparing notes and uncovering systemic failure.

References:

1. The Sun newspaper article on Obstetric Violence:www.thesun.co.uk/fabulous/8778305/birth-rape-obstetric-violence-investigation-childbirth/
2. The PSA's Morecombe Bay report and recommendations for the NMC: www.professionalstandards.org.uk/publications/detail/nmc---lessons-learned-review-may-2018
3. AIMS' review of the PSA's report www.aims.org.uk/journal/item/psa-review
4. Example of the failure of the NMC: www.fosteringchange.co.uk/unfit-to-practice/