AIMS For a better birth...

The midwife you have called knows you are waiting...

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by Pat Thomas

The first responsibility of a consumer group is to the consumer. This obvious statement is central to understanding the interactions between consumer groups and midwifery. Pat Thomas explores this complex relationship and the contributions that consumer groups have made to the promotion of midwifery care in the UK

The relationship between consumer groups and midwifery is a relatively new one, having its roots in the feminist/consumer movements of the 70s and 80s. However, for some time, support for midwifery care from groups whose interests and philosophies encompassed the wider aspects of pregnancy and birth (such as AIMS, the NCT and Maternity Alliance). However, as consumer groups tend to put more energy into affecting change at a clinical rather than political level, support for midwifery has increasingly become an important part of consumer group work.

Research consistently shows that, in general, women prefer midwives and that, with midwifery care, there is a greater chance that the woman will experience pregnancy and birth as a normal social and physiological event, rather than a medical and pathological one. Under midwifery care, women are less likely to use pain-relieving drugs and less likely to have their babies delivered instrumentally or surgically.

While somewhat outside of their usual scope, consumer groups have supported the idea that midwives must be selfgoverning and be given the opportunity to be trained in environments that are supportive and which help to give them confidence in themselves as skilled and independent practitioners. Midwifery, in turn, has benefited from the raised awareness that consumer support has helped to create.

Thus the relationship between midwifery and consumer groups is broadly perceived as symbiotic. However, recently, this relationship has evolved to reveal differences of opinion as to the definition of fundamental concepts such as risk, safety, choice and appropriate care. More vocal and campaigning groups such as AIMS have been critical of the fact that not all practising midwives are midwives in the traditional sense but are, instead, obstetric nurses whose first allegiance is to the hospital, to protocol and to the consultant obstetrician. AIMS has also been very public with the observation that an abandonment of traditional midwifery is akin to the abandonment of women.

As a result, we have entered the new millennium with consumer group support for midwives being rather more conditional - so that midwives, too, are feeling abandoned.

For midwives, this feeling is likely to be heightened by events outside of the consumer/midwifery relationship. Support for wider access to midwifery care is often not forthcoming from other professionals such as general practitioners and obstetricians. Nor is support for the traditional model of midwifery always immediately obvious from those who claim to represent and regulate midwifery, such as the Royal College of Midwives (RCM) and the Nursing and Midwifery Council (NMC). There is concern that the ongoing debate over how to define 'midwife' is being directed by midwifery managers with little clinical experience (as in the RCM) and by nurses who view birth as a medical event (as in the NMC).

The bigger picture

In recognition of the potential benefits for women, consumer groups have mostly refrained from openly criticising midwifery. Some still find open criticism of midwifery difficult and unreasonable since, on the basis of research evidence, birthing with midwives is safer and less likely to result in unnecessary interventions.

However, as they function largely outside of the healthcare system, consumer groups are in a position to see the bigger picture and to pick up on trends long before those working inside the system can perceive them. This is largely a result of consumer groups' efforts to construct a new kind of science one which uses a combination of observation, anecdote, dialogue, complaints and human input as well as the available scientific, sociological and psychological evidence to reach its conclusions regarding appropriate care, and to identify problems and opportunities for change.

Maternity care is different from other types of care in that the 'patients' are largely healthy women. Birth is not an illness. This fact alone means that current methods of research which rely on easily measurable outcomes do not adequately address issues such as psychological outcomes or the nuances of relationships and emotional needs.

Even in cultures where the midwife is a more autonomous practitioner, and where midwives and women regularly work together, resistance to this new 'science' is considerable. Kerreen Reiger noted that, in the course of a birthing services review in Victoria, Australia, professionals complained that including anecdotal evidence was "unscientific" and resisted conclusions drawn from such data.[1]

Yet, what a rich source of valuable information anecdote and observation can be. Ongoing dialogue between consumer groups and midwives has led to the revelation that a significant amount of bullying goes on within the profession, with medically oriented obstetric nurses wielding power over more radical midwives within the hospital system.

Bullying from colleagues, supervisors and consultants prevents traditional midwifery skill and autonomy from surfacing to disrupt the well-organised hospital environment.[2,3] Such bullying can have a negative effect even when the midwife is not in a hospital environment. However much the midwife may want to provide supportive care for normal labour at a home birth, she may be continually looking over her shoulder, fearful of criticism from her manager and the consultant. In addition, she knows that criticism is

more likely to come for failing to act according to hospital protocols than following her instincts as a midwife.

For this reason, many midwives continue to perform justin-case routines, hastening the erosion of their confidence and skills. However as consumer advocate Jean Robinson noted in 1997, trying to bring the hospital into the home can have dire consequences: "What some of our women are getting is not a home birth, but a hospital birth at home. Artificial rupture of membranes - even early ARM - is being done routinely and quite unnecessarily by some midwives. Some midwives are also acting like football coaches in the urgency and frequency of their instructions to push, despite the research which shows this is not helpful and may well be damaging. Nor are midwives necessarily allowing or encouraging women to adopt whatever positions during labour or delivery are most comfortable for them...the midwife who practises just-in-case interventions such as breaking the waters, or directed pushing, can create complications at home which there is no equipment to deal with."[4]

Observational studies of midwives' attitudes towards birth and motherhood have further revealed that, while the midwifery view of birth is more attuned to women's, significant differences can occur that are difficult to reconcile.[5,6] Hally McCrea and colleagues have found that women's needs with regard to pain relief are often at variance with the service the midwife is able or prepared to provide.

In her 1998 study, McCrea and coworkers noted the existence of "cold professionals" - midwives who were competent, but uninterested in having a relationship with the woman - who negatively influenced women's experience and perception of labour pain.[7]

Reports from women have also confirmed that not all women trading under the name of midwife are supportive, kind or enthusiastic about normal physiological birth.[8,9] It has also become apparent that what is good for the mother isn't always good for the midwife, and that midwives have resisted those changes that benefit mothers, but not them.

Water birth is one example of this. Women who labour in water feel safer, need fewer pain-relieving drugs and recover more quickly from giving birth. Yet, in recent years, many midwives have complained that women birthing in water are difficult to monitor and that attending such women leads to back strain for the midwife. Also, as debate has raged about when the mother should leave the water, many midwives dislike facilitating water births as this can potentially put the midwife into conflict with hospital policy.

It is common, even now, for anecdotal evidence to be dismissed as irrelevant, and for women's complaints of maternity care to be dismissed as selective and only coming from a small minority. Yet, a recent survey of 2000 mothers by Mother and Baby Magazine, whose readers are not among the 'select' population belonging to UK consumer groups, concluded that a significant number of women did not have their needs met by maternity services and that practitioners were often "cold" and "uncaring" and, in some cases, simply incompetent.[10]

The results of this small survey mirror those published many years ago when the popular British TV

programme That's Life asked 6000 mothers what it was like to have a baby in Britain[11]. The answers, which have been compiled into a book, highlighted the same sorts of problems women are struggling to overcome today-outdated inhumane care, lack of information, too much reliance on technology and no continuity of care.

Change in the maternity services is historically frustratingly slow. It is interesting to note that these same concerns were expressed in the report Human Relations in Obstetrics published in 1960[12]. Marjorie Tew has also noted that the social and emotional shortcomings of antenatal clinics have defied reform and that, as early as 1915, complaints about inhuman care, lack of information, long waiting times and the continual focus on the abnormal have been recorded[13]. Robbie Davis-Floyd has argued coherently that substantial shifts in the pattern of obstetric care cannot be achieved simply because the evidence suggests it should be so because clinical practice is a reflection of core social values that are centred around science and technology, the aim of which is to delineate between Man and Nature. Without concurrent social changes and a review of these core values, no change in clinical practice will be possible.[14]

The death of midwifery

Good midwifery is good for women. But what is being widely practised in UK hospitals is not good midwifery-it is obstetric nursing, a professional compromise constructed largely out of fear instead of concern for women's needs. There is little doubt that this kind of practice is the source of much of the current dissatisfaction with midwifery care. It is this type of medically oriented practice that consumer groups find difficult to support, and which has made it difficult and, in some cases, impossible for midwifery to fulfil its potential. Indeed, many proponents of traditional midwifery have now left the profession, frustrated by their inability to work as fully independent practitioners.

New government claims that money will be directed into recruiting more women into midwifery seem, on the face of it, to be encouraging. But what kind of profession will these women be recruited into? Whom will they be serving? What path will they follow and where will they be going?

The skills and knowledge that inform the practice of traditional midwifery in the UK are on the verge of extinction and it is not because consumers have somehow failed to provide enough support. For every door which consumer support has helped to open, more powerful forces appear to have placed strategic obstacles in the way to prevent midwives from crossing the threshold.

From the consumer's point of view, midwives have simply not fought assertively enough to retain traditional methods and knowledge. They have stubbornly refused to acknowledge themselves as part of the culture of women[15] preferring to create a hierarchical barrier between themselves and the women they serve.

This barrier, euphemistically called professionalism, puts the woman below the midwife. It also prevents the midwife from acknowledging the profound effect that each birth can have on herself and on the way her professional experiences resonate with her own life experiences. Sheepishly continuing to make the

hospital their professional home and drawn into the power struggles on which such large institutions thrive, midwifery has allowed the shift from vocation to profession to take place undebated and largely unchallenged.

A way forward

In countries such as Australia and New Zealand, mothers and midwives have formed radical groups that work together. Even in the US, consumer groups and midwives seem to be focused on the goal of redefining maternity care under the auspices of the Mother-Friendly Childbirth Initiative[16]. In the UK, however, consumers and midwives have remained, for the most part, separate. The radical midwifery group-the Association of Radical Midwives (ARM) - has maintained close links with consumers, and has regularly included the needs and rights of pregnant and birthing women on their own platforms. It is particularly telling that there has never been a group in the UK called Midwives for Mums or Midwives Against Unnatural Birth Practices. With the exception of the ARM, midwives have no radical groups to advocate for them or for the women in their care.

This may be significant and perhaps this reluctance to work in partnership with women can be explained by midwives' historical fear of conflict, and the imposition of an image of symbiosis and harmony "like it was in the old days". But this is not the old days. In the old days, the presence of a midwife was taken for granted and birthing women did what they were told. The new relationship between consumers and midwives is still relatively uncharted territory, but it certainly requires different skills and altered dynamics. For some, this altered relationship is a problem to be solved.

But a true relationship has no real endpoint or solution. It is ongoing and fluid, a dynamic interaction that will always include periods of conflict and concord, attraction and rejection. In any relationship, the potential for conflict is ever-present, and it is through the experience of negotiating conflict that we define and refine our needs.

Recognising and moving forward through these differences are what helps us to mature and grow. Consumer groups know this perhaps better than do midwives. This is why some will continue to take risks, issue challenges, give voice to criticisms-and implore midwives to begin to put the same energy into supporting women that consumers have put into supporting them.

UK consumer groups will continue to call on midwives to be courageous, to define themselves on their own terms, to see the positive potential of criticism and to not get lost in a self-defeating spiral of hurt feelings, but rather willingly enter into a robust dialogue and gather their strength for the difficult tasks ahead. Support for the true midwife who puts the woman at the top of her agenda will always be there. Support for the obstetric nurse will not.

Consumers and midwives can and should work together for change in the maternity service. Maintaining a connection with women is necessary to the existence and evolution of midwifery. Women are like the air and water to midwives, providing the fertile environment in which they can grow and change and (re)define themselves. Likewise, deprivation (selfimposed or otherwise) of women and their views will

certainly be the death of midwifery.

Those midwives who understand the importance of patience, non-intervention and relatedness are the most powerful partners women can have in the struggle to construct a maternity service that is safe and humane, fulfilling and relevant.

Consumers have put the call in. UK midwives must now decide whether to keep the connection or break it.

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