Midwifery – an existential crisis

In the UK, in 1960, the Peel Report suggested a goal of 100% hospital deliveries without any evidence whatsoever that this would improve outcomes.

The first campaigns for women to birth at home were based on a woman's right to birth wherever she decides. There was no research to support this demand but in 1985 Marjorie Tew published her research into the place of birth based on 1958 and 1970 surveys, both of which showed that women and babies were more at risk birthing in hospital. Her research encouraged a change in tactics, and women's groups started campaigning for home births on the grounds of safety, quoting her research. The evidence about the safety of home birth was disregarded by the obstetric profession and policy makers. In 2011 a national study of the place of birth of 64,538 healthy women and babies was published (Brocklehurst, 2011). Like Tew it found that women and babies were safer birthing at home, had fewer interventions and far fewer caesarean operations. This research has been largely ignored too.

Over time women have been persuaded, despite rigorous evidence to the contrary, that the only safe place to have a baby is in a large, centralised, obstetric unit. This false message is continuously reinforced by a climate of fear (Shallow, 2001d). Women are repeatedly told that birth is dangerous and if they challenge that belief they will be told that "*their baby could die*", and women who have safe, fulfilling and pleasurable births are told they are "*lucky*".

The over-medicalisation of birth, coupled with the 2008 economic downturn and increased hospital closures and obstetric mergers, has continued to the detriment of midwifery standards and practice. Midwives have had the principles of midwifery practice gradually and relentlessly eroded. Midwifery tutors are no longer a presence in the hospital as they have been absorbed into universities. Student midwives no longer learn the "*art*" of midwifery or the physiology of birth, they are required to obtain a degree and their training takes place mostly in obstetric units, a place where normal*, uninterrupted physiological, birth rarely takes place.

In 2002 the late Tricia Anderson, a very perceptive midwife, wrote an allegorical article, *Out of the Laboratory: Back to the Darkened Room*, describing how scientists had taken cats into a laboratory to observe them giving birth. They closely monitored the cats, that were isolated in sterile rooms,

watched by strangers, and found that cats had problems giving birth. Her article is an allegory of modern obstetric interference with birth and an appeal to return women to the safety of their own homes. https://www.pregnancy.com.au/out-of-the-laboratory-back-to-the-darkened-room/

Throughout many high-income countries, women and babies are damaged by over-medicalised obstetric care and, in the process, midwives have lost the concept of being "with woman". In stark contrast, women in low-income countries often do not receive the medical care they sometimes badly need, due to lack of resources. (Renfrew et al, 2014). Being with women is a skill that takes time to develop. By attending a woman antenatally, understanding her expectations and experience, watching and listening to a developing labour, the midwife hones her knowledge and understanding, and by so doing provides a safe environment for birth. Few midwives are enabled to provide this kind of care, because there are far too few midwifery led units (MLUs) and community based case-load midwives where this model of care can flourish. Instead, the majority of midwives practice as obstetric nurses in large, over-medicalised obstetric units.

MLU's do exist, but all of them have been under threat of closure at one time or another. In 2009, the Albany Midwifery Practice in south London, a group practice of midwives who worked both in and out of hospital, according to women's needs, had its contract terminated unilaterally on a false allegation that the Practice was unsafe (see Davies and Edwards, 2010). Their group practice was considered a beacon of good midwifery that should have been used as a template for the establishment of other midwifery practices, instead King's College Hospital carefully constructed an allegation which successfully closed them down with no opportunity to re-open, despite vigorous local protests.

In 2016 the National Maternity Review stated that: *"This report envisages more births taking place in the community …"*. This vision is best achieved by case-load midwifery in the community and in small MLUs. In 2018 there were only 61 freestanding MLUs in England. These units offer midwives the opportunity to practice midwifery, as opposed to obstetrics, and enable women to birth normally, and have better outcomes than their nearby obstetric units (Sandall, 2015). An overall shortage of midwives in obstetric units has commonly been used as an excuse to close MLUs, citing "*safety"* as the rationale for the closures when, in reality, it was the obstetric units that were unsafe, requiring the midwives from the MLUs to bolster their inadequate establishment.

A similar rationale of closure has never been applied to dysfunctional obstetric units. Were that to happen they would all be closed down.

There has always been a shortage of midwives, but the current situation is critical. Many senior, experienced, midwives, as well as disillusioned student midwives, have resigned in recent years, unwilling to put their health at risk working in environments that are stressful, bullying, dysfunctional, and grossly under-staffed. Working in such units puts midwives in the impossible position of having to deal with the mis-match between the concept of being "*with woman*" and the demands of the institution which often takes precedence (Hunter, 2004) and is governed by the clock and protocols. It is interesting how women are often told that "*every birth is different*" yet when they go into a hospital they are required to fit into a carefully restricted standardised set of protocols.

The government, in response to this crisis, has promised to increase midwifery students by 3,000, but research has shown that only 1 in 20 students stay in midwifery after qualification, which means that this, so called, increase will only result in 150 extra qualified midwives; and affords little confidence in the proposed plans to encourage retention of the more experienced midwives.

The decline in midwifery practice has been remorseless. One might expect that during this time the Nursing and Midwifery Council and the Royal College of Midwives would be focused on protecting midwifery. If only. At one time midwives in the United Kingdom had their own Midwifery Council, but this was absorbed into the UK Central Council for Nursing and Midwifery (UKCC) which then became the Nursing and Midwifery Council (NMC). I sat as a lay woman on the separate Midwifery Committee of that body, alongside 20 other midwives, nurses and doctors. Over the years, the Midwifery Committee was systematically reduced, and then abolished. The NMC then reduced its Council to 12 members, none of whom identify as a midwife. Increasing numbers of midwives have been reported to the NMC, and forced to endure its tortuous procedures, often eventually cleared of the allegations, but so traumatised by the experience that they leave midwifery. The Royal College of Midwives has similarly failed to support the physiology of birth and the autonomy of midwifery practice. Their failure has resulted in an open letter calling for the resignation of the board members https://www.midwifery.org.uk/news/open-letter-to-the-board-and-ceo-of-the-royal-college-of-midwives/

Meanwhile, the over-medicalisation, and industrialisation, of birth has been relentless, despite women's groups challenging and exposing the lack of research evidence that would justify this model of care for all women.

For example, during the 1960s it was common for all women expecting their first baby to undergo a routine episiotomy. The Association for Improvements in the Maternity Services (AIMS) and the National Childbirth Trust (NCT) challenged its use. The campaign resulted in the first midwifery research programme enabling midwife Jenny Sleep to research (1984) the use of episiotomy. She found no evidence to support its routine use.

Fast forward to 2022 and midwife Amanda Burleigh's tireless ongoing campaign to initiate delayed cord clamping, in the face of derision and opposition from all sides. https://waitforwhite.com/about-amanda-burleigh/ Delayed cord clamping, however, has now become mainstream to the direct benefit and safety of babies.

The most common intervention of all is synthetic oxytocin or pitocin, which was introduced as a means of helping women whose labours had become seriously overlong. In Ireland it was developed as a means of processing women through the hospital as quickly as possible. This arose because the doctors had closed most of the small, local, birth centres and, as a result, the large, centralised, obstetric units became overwhelmed with labouring women. Induction was sold to women on the grounds that the staff could guarantee that their labours would not last longer than 24 hours. As the years passed, and the numbers of admissions increased, this guarantee was reduced in 1972 to 12 hours (O'Regan, 1998). Today, the justification for this intervention has changed, it is now focused on being "*overdue*". Women are routinely pressured to have an induction by 41 weeks, despite the fact that a normal birth can occur any time between 37 and 42 weeks or even later, without ill effect (Wickham, 2021). Induction of labour has become a pandemic, and the adverse outcomes: depression, damaged sex lives, suicide,

marriage break up, and fretful or damaged babies, has yet to be researched properly (women's letters and phone calls to AIMS (1960 – 2017).

These issues form the background to the latest scandal to hit the National Health Service (NHS). On the 31st March 2022 the final Ockenden Report was published. The report investigated the adverse outcomes at the Telford and Stafford NHS Trust over the last 20 years, and revealed: a catalogue of poor care, incompetence, and poor inter-professional relationships that resulted in the above average deaths of women and stillborn or damaged babies. A tragedy arising from the pressure of having a target for caesarean operations which led to dangerous care - especially inappropriate vaginal births. The investigation only came about as a result of a long and sustained campaign by two couples, Rhiannon Davies and Richard Stanton, and Keyleigh and Colin Griffiths who had lost their babies and who knew that there were many others who had had similar experiences.

Following the publication of the Ockenden Report newspapers carried headlines claiming that it was the biggest NHS scandal ever and, despite the evidence of a dysfunctional, over-medicalised, obstetric unit, blamed a drive to reduce caesarean operations and promote "*normal*" birth, when in fact they should have linked the reduction in caesareans with the drive for increased vaginal birth. Normal birth and vaginal birth are two very different things (see definition below).

Telford and Stafford NHS Trust prided itself on having the lowest caesarean operation rates in England while, allegedly, promoting "*normal*" birth. Interestingly, the report only mentions "*normal*" birth three times but does not clarify what would qualify as "*normal*" (p 9.24). Mothers are routinely over-medicated with drugs to bring on contractions that may or may not lead to a vaginal birth. A vaginal birth in this context is not the same as a normal, uninterrupted birth, but, sadly, women themselves mistakenly assume that because the baby arrived vaginally they had a normal birth. The media consistently fails to understand the difference between a normal uninterrupted physiological birth and a vaginal birth *"at all costs"*. From the descriptions highlighted in the Review one can infer that all the women under review, had interventions during their labours, or had labours that had deviated from normal, but no action was taken.

Very worryingly, one could carry out similar investigations into any obstetric unit, anywhere in the UK, and come to similar conclusions. Large, centralised, obstetric units are high risk, dangerous, environments not fit for well and healthy women and babies.

There is a widespread failure to understand what normal birth is. The NHS Maternity Statistics for England 2019-20 shows that 52% of women have "*normal*" deliveries. This figure includes women who have had artificial rupture of membranes, augmented labours, electronic fetal monitoring and a managed third stage. In reality, I estimate that fewer than 1 in 10 women have a normal birth in our large, centralised, obstetric units.

Rather than focus on over-medicalised births in these dysfunctional obstetric units, normal birth has been demonised and used as a means of deflecting attention from the reality of over-medicalised, under resourced, maternity care in the UK. There is no "*cult*" of normal birth. The reality is that there is a pandemic of induction or acceleration of labour to process women through grossly understaffed and overly busy obstetric units and, as a result, staff fail to recognise deviations from the normal physiology of labour. This is the problem, not an "*ideology of normal birth*" (The Sunday Times 2022).

In 2015 a similar enquiry into deaths of mothers and babies who died over an eight-year period at another NHS Trust came to similar conclusions (Kirkup, 2015). Over the years there have

been many more enquiries and even now the results of yet another obstetric unit enquiry are awaited.

I have no doubt that there will now be a concerted effort to tighten up on procedures and training with little regard to midwifery models of care. The Ockenden Report has made a number of recommendations, but none of them address the need to support and enhance fundamental midwifery practice.

For there to be real change and a stop to this pandemic of induction and over-medicalised care, midwifery needs to be removed from obstetric control. A separate community midwifery Trust could be established with Free Standing Midwifery led Units in every area supporting case-load community care, along the lines of the Albany Midwifery Practice but outside the control of the local Trust. Midwives also need a separate Regulatory body and a Board of the Royal College of Midwives that actually promotes and protects midwifery practice.

Antenatal classes, in the meantime, need to spell out the difference between a normal, physiological, birth and a vaginal delivery and challenge those who muddle the two (see definition).

Over the years, midwifery research has grown and has repeatedly and consistently demonstrated that women and babies have better outcomes when enabled to have the continuous care of a qualified midwife. The profession of midwifery is in crisis and policy makers and politicians need to recognise the reality that medicalised births require the skills of an obstetric nurse, and a midwife cannot be both. The profession needs to face up to this dilemma before midwifery and its core professional role is lost.

Put in a box?

***A definition of a normal (physiological) birth and vaginal (medicated) birth**

Normal (physiological) birth

Spontaneous onset of labour after 37 completed weeks of pregnancy

Labour progresses without artificial stimulants

Mother births her baby spontaneously through her own efforts

The placenta is birthed spontaneously after the birth of baby

Vaginal birth

Defined as any baby born vaginally

Mother may have had:

- a membrane sweep to stimulate labour onset;
- labour induced with prostaglandins or accelerated during labour with oxytocic drugs;
- continuous intravenous infusion in progress;
- fetal heart continuously monitored with cardio tocograph (CTG);
- the delivery of the placenta managed with uterine stimulants (syntocinon) and active cord traction or with Caesarean section the placenta is manually removed by the surgeon

The mother's ability to move about and aid labour progress may be restricted

Pain is often increased requiring opioid or regional anaesthesia (epidural)

There is an increased chance of:

instrumental birth (suction cup or forceps)

a caesarean operation

NB Evidence has shown that the safest way to give birth is to have the continuous support of a known caregiver (a midwife).

Beverley Ann Lawrence Beech
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