THE ASSOCIATION OF RADICAL MIDWIVES

Submission of evidence to the safety in maternity care committee.

The Association of Radical Midwives is a charity set up in 1976 by midwives, students and mothers who recognised that the profession was in danger of losing both its roots in the community and its central philosophy of being ‘with women’ in childbirth.

In 1986 ARM published The Vision: proposals for the future of the maternity services in the UK. Some of the recommendations that seemed very radical then have been achieved, such as “Midwifery training will be primarily be a 3-year direct entry course” (ARM, 1986)

Other recommendations became an established part of policy documents in England, (Changing Childbirth, DoH, 1993; Maternity Matters, DoH, 2007), particularly around continuity of midwifery care. The more recent document from NHS England The National Maternity Review “Better Births” (2016.) continues to support continuity of carer as the single most effective aspect of maternity in maintaining safety and well being of women and babies.

EVIDENCE

Relationship and communication are the foundation of all good healthcare, the best clinicians are able to convey unconditional positive regard and inspire confidence in their clients that their holistic needs will be fulfilled, and the safest evidence-based care supplied.

Mothers need personal care throughout the childbearing year: ‘All mothers need a midwife while some need an obstetrician too’ (Shribman, Maternity Matters, 2007). Midwifery care is a personal service based on a one-to-one relationship between a midwife and her client, a relationship which has been described variously as a ‘professional friend’, ‘professional servant’ and ‘mothering the mother’ (Walsh, 1999; Cronk, Taylor, in: The Midwife Mother Relationship, Kirkham, 2010). Midwives and mothers may be supported by maternity assistants who are partnered with midwives providing additional help in the antenatal, intrapartum and postnatal period. Some institutions are already developing successful models on this basis.

Place of Birth

While many freestanding birth centres currently appear to be thriving (Gutteridge, 2011), their number fluctuates from month to month and year to year as they are opened and closed either temporarily or permanently. Some freestanding birth centres fail to reach their
potential owing to a combination of lack of managerial support, medical prejudice, cost cutting, staff shortages and lack of political championing (Deery et al, 2010), while others are under constant threat of closure, either for financial reasons or staff shortages.

The Birthplace study (Birthplace in England collaborative group, 2011) showed that women take up to 40% longer to deliver their babies in obstetric units than they do in midwife-led units or at home (obstetric units 9.01 hours, alongside midwifery units 7.92 hours; free-standing midwifery units 7.49 hours; home 6.6 hours. Birthplace Study, Final report part 5).

The maternity services must be restructured to provide safe, woman-friendly care and enable the majority of midwives to practise the full range of midwifery care according to the International Confederation of Midwives’ definition of a midwife:

ICM Definition of a Midwife

“The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility.”

Recruitment and Retention

Midwives are leaving the profession because they do not wish to practise as obstetric technicians (Ball, Curtis and Kirkham, 2002) and lack the time to give woman-centred midwifery care. Many others work only part-time because midwifery has become a constantly stressful and exhausting occupation. Midwives are losing their professional status as they have less and less control over how, when and where they work. We know that midwifery care can have a very positive impact upon mothers’ childbearing experience and on long-term and short-term clinical outcomes (Hatem et al, 2008). During labour, we know that the continuous presence of a supportive companion can help mothers and improve outcomes (Hodnett et al, 2007). We also know that continuity of care from a known midwife throughout the childbearing year can improve clinical outcomes (McLachlan, 2012) and family relationships (McCourt and Stevens, 2009).

In the context of a rising birth and case complexity rate, and a shortage of midwives, it is important to develop ways of working which encourage experienced midwives to stay in the profession. The aim would be to improve safety and skills and centre maternity care predominantly in the community. This would also take the pressure off acute trusts which see and organise maternity as an emergency service allowing obstetrician led care to be focussed on women with more complex pregnancies.

Professional Regulation

Continuity of carer provided by a professional as described above should not be a luxury as there has been overwhelming evidence over many decades of the benefits, not only of improvements in safety and health outcomes but financial cost reductions. The NMC has provide robust new standards for midwifery proficiency and education of midwives (NMC
2019) which are based on the Lancet series (Renfrew 2014.) We anticipate these standards will underpin and give confidence to midwives in their practice. ARM has expressed concerns about midwifery regulation in the NMC and has proposed that the lack of balance in numbers of registrants caused the unique concerns of midwifery and maternity care to be overlooked. Good regulation is vital to maintain public safety and support good practice and involvement of professional and lay bodies needed to promote balance and an open culture. There has been some recent progress in communication and collaboration from the NMC who have sought midwives to sit on the board and council and improvements in fitness to practice proceedings. ARM continues to monitor progress and considers separate midwifery regulation under the auspices of the HCPC, with involvement of lay and professional stakeholders may be a potential model if change proves illusive.

Recent investigations into failures of high care standards within hospital trusts reflect trends over many years. ARM is optimistic that the continuity of carer starting to be implemented consequent on the National Maternity Review (2016) will lead to improvements in safety and satisfaction with all aspects of care. Good professional regulation is a fundamental foundation of improvement

*Maternity services should be organised in a way that enables and encourages women to have a midwife they can get to know and trust to support them antenatally, for the birth and in the postnatal period, which is particularly important for establishing and maintaining breastfeeding.*

**Financial Aspects of Maternity Care and Insurance**

We see “no fault compensation” as the way forward for families and maternity services. The present problems of CNST-led care are adversely affecting mothers and their babies. All births should be covered by no fault compensation as a more equitable way of supporting those families who may have lifelong care needs. It would also mitigate against fear based defensive practice and “blame culture”. This would not obviate the need for professional indemnity insurance but would make it affordable for all midwives and for NHS Trusts. No fault compensation for births of all UK citizens would enable independent midwives to access affordable professional indemnity

The benchmark of safe and affordable maternity care should be good maternal and infant outcomes, the normal birth rate and low levels of mortality and morbidity. Payment by Results should be configured to support preventative care and reward those who achieve the best clinical outcomes with the least intervention. We support the proposals of the National Maternity Review which seeks to allocate funding individually to childbearing women which can then be spent on the care she needs or wishes to choose. It is important that midwife and community led care in low risk settings does not appear to be more expensive than hospital care and high rates of medical intervention; at present when the funding relating to birth care is entirely allocated to the institution where the birth takes place, even if there have been many hours of care given outside that institution.
Basic Principles.

- Care should promote the health and well-being of the childbearing woman and her baby; the aim should be to facilitate the safest and smoothest transition to parenthood.
- The mother is the central person in the process of care.
- The relationship between mother and midwife is fundamental to good midwifery care (Kirkham, 2010).
- All childbearing women should have access to their own personal midwife throughout the childbearing period.
- All women should exercise fully informed choice in childbirth including the right to decline treatment. Choices would include type of care and carer, the place and manner of birth (which includes home birth, now enshrined in European law (Ternovszky v. Hungary 2010)).
- Midwives have a duty to help women choose the best type of care for them but should avoid coercion into compliance with professionally favoured choices.
- The majority of care should be based in the community (RCOG, 2011). Midwives are the professionals best equipped to support normal birth; ways of working that ensure that their skills are fully used should be developed.
- Women have the right to give birth in a calm and peaceful environment whatever the birth setting; women’s privacy should be respected.
- Service providers should be accountable to women and their families.
- Professional regulation is a foundational to good practice.
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