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Maternity care in action~ Intrapartum Care

A report of a conference held at the King's Fund Centre on 26 July 1984
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King Edward's Hospital Fund for London

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FOREWORD

In recent years the British way of birth has become a major focus of critical attention for consumers, social scientists and the media, as well as for some of the professionals involved. When we compare the woman entering labour today with her counterpart at the turn of the century it is not difficult to see why. Today's woman will usually have no previous experience, as an observer or helper, of the birth process, so that in going into labour she enters what is for her uncharted territory. She will have far fewer babies over her reproductive lifetime and may therefore attach greater importance to each birth. She may have a male partner who wishes to be involved in the birth and who, like her, defines the birth of this child as a significant event for their relationship. Childbirth is a physiological process which marks a major psycho-social transition for the individuals concerned and for their relationships with each other. Social scientists suggest that the quality of these relationships - of mother, father, and infant - are significantly affected by the quality of the birth experience itself.

On 26 July 1984 a conference was held at the King's Fund Centre to discuss the second report of the Maternity Services Advisory Committee 'Maternity Care in Action - Care during Childbirth (Intrapartum Care)'. The purpose of the conference was to consider how health authorities, professionals, voluntary groups and consumer organisations could best contribute to the enhancement of the birth experience for parents and infant. Particular attention was paid to implementation of the guidelines contained in the Report and to the factors which appeared to facilitate or inhibit the establishment and effective functioning of district Maternity Services Liaision Committees.

I should like to thank all conference participants for their contribution to a stimulating and valuable occasion. We hope that this Report will extend the discussion beyond the boundaries of the conference and will be helpful to those who are trying to implement the Report's guidelines in their own localities.

June Huntington
September 1984

MATERNITY CARE IN ACTION - INTRAPARTUM CARE

Report of a conference held at the King's Fund Centre on 26th July 1984, to discuss the second report of the Maternity Services Advisory Committee, "Maternity Care in Action - Part II - Intrapartum Care".

Chairwoman's Introduction

Ruth Evans, Coordinator, Maternity Alliance

Ruth Evans described the context in which the conference was taking place. The 1980 Parliamentary Short Report on perinatal and neonatal mortality contained a daunting 152 recommendations. It was criticised by mothers for being too much in favour of new technology and by others for its cost implications for Health Authorities. The Maternity Services Advisory Committee (MSAC), was set up by the Government in 1981 to confront these problems. The MSAC had brought out reports on ante-natal and intrapartum care and were at work on postpartum care. Meanwhile, Parliament had produced a follow up to the Short Report. This looked at what had happened since 1980 and made disturbing reading. While overall perinatal mortality and morbidity figures were down, the gap between social classes I and V was actually increasing and there appeared to be no improvement in figures for ethnic minorities, especially Pakistanis.

The MSAC reports had been criticised for not laying down national minimum standards of maternity care. On the other hand they had gone a long way towards meeting womens' requirements in contrast to the Short Report.

The conference was to look at practical ways of implementing the MSAC recommendations on care during childbirth. The DHSS had given these recommendations strong backing and would in the future be monitoring their implementation at District level.

The central thrust of the day was a consideration of the Maternity Services Liaison Committees recommended by the MSAC: how to set them up, what factors facilitated and inhibited their creation, and how to make them work.

Ruth Evans then introduced Alison Munro who as Chair of the MSAC and Chair of Chichester Health Authority, had practical knowledge of the problems.

Maternity Care in Action: Part II - Care During Childbirth (Intrapartum Care) - Implementing the Guidelines. Alison Munro, Chair of the Maternity Services Advisory Committee and of Chichester Health Authority.

Background to MSAC reports

Alison Munro began by telling the conference about the MSAC. It was made up of representatives from all the professions dealing with maternity care, plus two lay members who had played an important role in representing women's views. The Government had given the MSAC very wide terms of reference, and had not told them how to go about their task. They took two important decisions at the outset. One was to produce a slim, readable, non-academic yet decisive report. The other was not to take evidence, since there was no shortage of analysis already. What the NHS lacked was decision and action. The checklists made it simple for everyone to apply their minds to implementing the practices outlined in the report. The DHSS had risen to the occasion and had sent out 11,000 free copies.

Need for trust and communication between mothers and professionals

In the first part of Maternity Care in Action which dealt with ante-natal care, the issue that stood out was the tremendous burden on ante-natal clinics leading to an unsatisfactory service for the mother. In the second part of the report, the outstanding issue was the enormous groundswell of dissatisfaction from mothers. Alison Munro did not accept that this was just middle class, left-wing dissatisfaction. She cited ghastly reports of birth in womens' magazines which aimed at all different social groups as an indication of the widespread antipathy to current practice. Why she asked, given all the new equipment and practices and safer childbirth, were women so dissatisfied with the service, and why were they questioning whether procedures were necessary at all? She felt it came down to a lack of trust caused by a lack of good communication. Parentcraft classes were not the complete answer. Good relations and trust between mothers and professionals must be created during the ante-natal period if they were to have confidence in the procedures they might meet.

Aspects of the Report

Respect for mother's wishes

Advance birth plans, agreed with the mother and flexible enough to accommodate change, are vital. Mothers should be offered a say in every aspect of their care. Full explanations should be given to mothers who did not want procedures that professionals thought might be medically necessary, together with the opportunity for discussion. In the end, it was the mother's body and the mother's baby. For their part, senior consultants should make sure that in their departments procedures were not abused and were done entirely in the mother's and baby's interest.

Monitoring of procedures

On complications of child-birth, the Committee recommended that RHAs should monitor the incidence of complications and of obstetric procedures to assist clinicians in the assessment of their practice. This could be very revealing of the standard of clinical care.

Consent to procedures

On the question of consent, Alison Munro stressed that the general consent on which hospitals usually rely has no value. She used the example of episiotomy. Professionals sometimes said that labour was not the time to ask for consent, but she maintained that episiotomy should have been clearly explained and disucussed beforehand. Episiotomies should not be done routinely, and consent should always be requested.

Emergencies

The Committee were very concerned about emergencies and flying squads, because of the demands made on delivery suites if obstetricians and midwives were called out. There could be safer and more reliable alternatives. Whatever system was used it needed to be kept in tip-top condition.

Home births

Alison Munro rejected the criticism that home births had not been integrated into the body of the report. The Committee were unanimous that hospital births were best and recommended the domino scheme for mothers who wanted to be at home. Nevertheless, they had recognised that home births would always be requested by a few, no matter how much the hospital service improved. Their concern had been how to make home births as safe as possible and the checklist would help monitoring of the procedures for home births.

Design and equipment

Both new and old maternity wards should adopt single stage rooms which should be homely with not too much clinical equipment around.

Minimum standards

Alison Munro said that the DHSS had tried to come up with minimum standards and found it very difficult. The Department had handed the problem on to the MSAC. She felt there was confusion about the term. There was a basic minimum without which you could not run a proper service, and this was mentioned in the report, eg, a doctor with no conflicting commitments should be available 24 hours a day for the delivery suite. What critics of MSAC's report meant were not miniumum standards, but targets for numbers of staff, equipment, beds and so forth. She disagreed. Targets did not increase resource standards, but proper evaluation made a better case. The checklists were there to help that evaluation.

She gave the example of her own District where an active MSLC had used the checklists to show up deficiencies in the service. More resources had then been forthcoming, for example, to increase the numbers of Community Midwives and to introduce single stage delivery rooms. Because of the problems of inertia in the NHS, MSLCs were essential agents of change. Consultants had to face the need to involve all the disciplines in decisions about services. Go out and spread the message, said Alison Munro, for something is still very wrong with parts of this country's maternity services.

Questions and Discussion

In the discussion which followed, Dr. Gordon Taylor, GP member of the MSAC, made the point that while the Committee's report talked of improving women's choices, in fact choice was being reduced all over the country by the closure of GP obstetric units. GP obstetrics was the cinderella of the maternity services. GPs were under pressure from aggressive consumerism, they were offered only patchy consultant support and poor provision of refresher courses.

Dr. Bob Lyle, a GP from Hackney, said GP obstetrics were not a question of resources. In Hackney GPs used a room in the local maternity hospital. Successful GP obstetrics were based on good relations between midwives, GPs and hospital doctors, and these were achieved in Hackney through an obstetric workshop which regularly brought together all the professionals involved in maternity care.

A consultant, who wanted to remain anonymous, said relations with mothers had become very difficult because of articles in magazines and the work of voluntary bodies. Women who were ill-informed often came to the maternity services with pre-determined views that made dialogue and compromise difficult.

Alison Munro agreed, but said it was not possible to stop the expression of dissatisfaction in a free country. It was a communication problem for professionals and required a lot of time.

Professor Brian Hibbard from RCOG said the problem for doctors was not to allow the confrontation expected by women to take place. If doctors took trouble to talk with women, confrontation could be avoided and good relations result.

Sandar Warshall from the Association for Improvement in the Maternity Services (AIMS) said that women now wanted to trust themselves. They did not want to blame doctors if things did not work out. Doctors had to listen and learn from women, then women in their turn would stop complaining and start taking responsibility for their own decisions.

Dr. Rosemary Graham, a Specialist in Community Medicine, disagreed. No mother could understand the implications of and need for medical procedures. Women could not be allowed to take on responsibility for what happened during labour if the result was a handicapped child.

Dr. Joyce Leeson, a District Medical Officer, said that many of the procedures used in maternity care had not been subject to proper randomised control trials. Since experts disagreed so much, it was difficult for doctors to claim the right to overrule women.

Professor Hibbard supported Alison Munro on the question of minimum standards. Situations varied. Some obstetric and gynaecological units were in the same building, and some were miles apart. The demand that a doctor with no other commitments be available for the delivery suite 24 hours a day had enormous resource implications which could not be dodged. The guidelines were not cheap.

Ruth Evans said that equipment like incubators was lifesaving. The question was whether we wanted such equipment. There was a struggle for cash but the money should come from Government.

Dr. Leeson made the point that buying machinery was not always the best use of resources. She thought that improved diets would make more difference to the health of women and children in Britain than pieces of equipment.

Ruth Evans said that the Maternity Alliance's report on diet had cost implications for the DHSS because it showed that Supplementary Benefit rates were insufficient to provide a pregnant woman with an adequate diet.

Ensuring standards: The Role of the Community Health Council.
Helen Rosenthal, Vice Chair, City and Hackney CHC and Penny Wallis, co-opted member.

In an effort to extend more information and choice to women in the district, City and Hackney CHC had produced a booklet 'Pregnancy and Birth in Hackney and the City of London'[1]. Helen Rosenthal described this guide to the maternity services in City and Hackney Health District.

When women went to their GPs on becoming pregnant they were not offered all the choices available because the GPs had their own preferred way of doing things. The aim of the guide was not to promote any one form of care. In placing home birth before hospital birth, in a section on choices available, the guide aimed to redress the balance that was so strongly in the hospital's favour.

(1) 'Pregnancy and Birth in Hackney and the City of London: How to make the maternity service work for you in City and Hackney Health Districts' Guide prepared by City and Hackney Community Health Council, 210 Kingsland Road, London, E2 - cost £2 (available free of charge to people living in City and Hackney)

Information about choice was also made available in a short, snappy leaflet so that although everyone might not read the guide, they would have easy access to the facts about choice.

The Women's Health Group of the CHC was aware of discrepancies between policy and practice in the District's maternity units, and the lack of policy on some issues. Interviews with staff at all levels highlighted these differences. There were also clear differences between the two maternity units in the District. The guide made a comparison of the two, setting out side by side what could be expected in each unit. Different intervention rates in the two units were set out in a table. A cameo description of each consultant was also given. Some of this made uncomfortable reading for health service staff, but was almost entirely factual.

In a section on the mother's say on medical procedures in labour, the intention was not to influence choice, but to give clear information. The guide took a different line from 'Maternity Care in Action' which stated eg, that women will accept normal procedures if they are explained. For the purposes of the guide this was not sufficient, given the differences between policy and practice over the use of medical procedures and intervention in the hospitals. The guide also suggested women wrote a letter in advance saying what they wanted during labour and many midwives have welcomed this. There is evidence that the guide has acted as a catalyst for the creation of policy where it did not exist, and for changes in procedure.

The guide is free to City and Hackney residents and is available through libraries and clinics and the CHC. GPs are on the whole pleased with the guide, although it presents them with a challenge. The guide was written and printed with money from Inner City Partnership.

Ante and post-natal groups

Penny Wallis, member of the Hackney and City CHC, described her work with ante- and post-natal groups. She recruits members for the groups in ante-natal clinics. The groups start out as pre-natal groups but quickly become post-natal also. The chief advantage is that pregnant women are helped to see beyond the birth. The groups cover the topics the women choose. Penny Wallis does not teach. Learning comes through discussion.

Ante-natal clinic

She became aware just how many women in the hospital ante-natal clinic did not attend ante-natal classes. With the midwife who runs the parentcraft classes, she wrote a breastfeeding quiz. She used it with all the mothers waiting in the clinic one morning and found it set the usually silent clinic alight. Penny Wallis wants to do more work along these lines reaching women who are not normally reached by classes.

Sessions with the medical students

Because so many mothers express dissatisfaction with their doctors, the women's health group of the CHC wanted to discover how medical students were trained. At a meeting with the obstetric consultants it was agreed that members of the group should give students a consumers' view of the maternity service. Both members who do the sessions have three children and are in contact with many Hackney mothers.

The sessions cover ante-natal care (through discussion) and labour (through a role play). The students themselves are able to think through how women feel in ante-natal clinics about the long wait, lack of facilities etc., though they rarely mention tiredness of early pregnancy and feelings about change of shape. The question of how the ante-natal experience can be improved is discussed and the two CHC members make it clear they do not have easy answers.

The role play is an exciting part of the session. Everyone is allocated a role and the outcome of the labour - a forceps delivery - is decided in advance. "Cross roles" are given wherever possible, a male student taking the part of the labouring woman, and if a midwife is present, she is asked to be the doctor. Although everyone has a laugh, to work well the role play needs to be done with some seriousness. It continues for 20 minutes or so. Afterwards students comment on the narrowness and height of the bed, on the tightness of the monitor and on their feelings of confusion about what is going on. They sometimes express reservations about how labour and birth are conducted at the hospital. Penny Wallis suggests that they talk on the post-natal wards to mothers whose births they have attended to find out whether the women have the same impressions as themselves. The sessions are valuable in getting students to question what they are taught and to think about policy and procedures from a different standpoint.

Questions and Discussion

In reply to questions from Carol Eccleshare, a Maternity Unit Administrator who was interested in producing a similar guide, Helen Rosenthal said that the guide had not been translated into other languages but the ethnic minorities project countered that problem to some extent.

No formal monitoring of the guide's impact had occurred, but feedback from, for instance, Penny Wallis' groups was very positive.

Helen Rosenthal pointed out the problems of a DHA producing such a consumer oriented guide.

Heather Rutt, Vice Chair of NW Herts CHC, asked how the community health project was funded. Helen Rosenthal said that the CHC was lucky to have access to Inner City Partnership monies, but they were coming to an end and the CHC was pressing the District to give the project mainline funding.

Gordon Taylor ended the session by congratulating City and Hackney CHC on its achievements.

Ensuring standards: Establishing Effective Maternity Services Liaison Committees - Small Group Discussions

The conference then divided into 9 groups, each group containing some members who worked in Districts with and without MSLCs and some members who did not know whether MSLCs had yet been established in their districts. Each group identified factors which inhibited and which facilitated the establishment and effective working of these Committees. The results of the groups' deliberations are summarised in Table I.

TABLE 1: Factors Facilitating and Inhibiting the Establishment and Effective Working of Maternity Services Liaision Committees in Health Districts

Facilitating Factors	Inhibiting Factors
1) Health Authority initiation and/ or backing and support. 2) Enthusiastic chair. 3) Clearly established objectives and terms of reference. Distinctions made between measures that cost and measures that do not. 4) Access to statistics and necessary information. 5) Clear organisation from the outset so no geographical/language problems. 6) Clear thinking about relations to work of already established committees which deal with only part of ground to be covered. 7) Necessary resources to function actively. 8) Wider and proper representation of all interested parties both lay and professional. 9) Non-hierarchical methods of working. 10) Pressures from outside bodies. 11) Problem in the service that needs to be tackled immediately. 12) Use of Materntiy Care in Action checklists	1) Complacency and lack of initiative. 2) Anxiety by professionals about clinical freedom and practice. 3) Resistance to lay in put from professionals and Health Authorities. 4) Aggressive lay members upsetting professionals. 5) Lack of immediate concrete benefits for participants being more important than concern to provide service. 6) Confusion about role in relation to for instance the planning team. 7) MSLC being an addition to large number of existing committees instead of integrating them all. This leads to confusion and time wasting. 8) Lack of commitment from influential members (eg consultants) who do not bother to attend. 9) Health Authorities having different priorities. 10) Too long a time taken to see change/results

Intrapartrum Care: The GP's Perspective. Dr. Luke Zander, Senior Lecturer, Depart. of General Practice, St. Thomas' Hospital Medical School, London SE11.

Luke Zander addressed two principal issues: the nature of general practitioner obstetrics; and how to achieve change.

In attempting to put the topic into an appropriate context, Dr. Zander quoted from the introduction of the recently published McNaughton report of the Royal College of Obstetricians and Gynaecologists which considered ante-natal and intrapartum care, in which it stated 'The Working Party's discussion has taken place against an almost unparalleled background of public debate about maternity services. Much of this has been highly critical of obstetric care as practised today. Techniques which are regarded as interventionist have been particularly criticised and it has been suggested that we have become over-obsessed with safety in childbirth'. A recent WHO report comparing England and Wales with eight other continental countries showed that the UK is top of the league in the medicalisation of birth. While the improving perinatal and neonatal mortality figures are constantly being used to indicate the success of the service, perhaps it is time that we reconsidered the parameters by which we measure the quality of pregnancy care.

The significance of the Generalist's role in intranatal care

The role of the general practitioner in intranatal care should not be judged solely in terms of which aspects of the maternity service he (she) could conveniently provide. Its importance lay in the fact that there is a significant difference between the nature of care provided by the generalist and that of his specialist colleagues. The central characteristics of general practitioner intranatal care are:

(a) It is the obstetrics of non-interference.

(b) The central figure is the midwife, who is encouraged to function in her real role as an independent professional, monitoring and facilitating the process of normal labour.

It is important to recognise that general practitioner intranatal care is under serious threat because of the continuing closure of independent GP maternity units. Luke Zander felt that the care provided by a general practitioner attending a birth in a consultant maternity unit would inevitably be influenced by the proximity to specialist expertise and the increased use of technology. Opposition to the reduction of General Practitioner units stemmed from a concern to protect a particular form of intranatal care and not from a desire to protect professional territory.

Dr. Zander referred to a recent study by Michael Klein* in which the care provided to a group of mothers in a GP unit in Oxford was compared with that given to a matched control group in the associated consultant unit. The GP unit had been shown to have a consistently lower rate of intervention and higher Apgar rating for the babies. Three years later, the differences between the units were much reduced, largely because the care provided in the consultant unit now approximated more closely that of the general practitioners. This study underlined the importance of maintaining different models of intranatal care.

Luke Zander defended the continuation of home births on the grounds that they provided a much valued option for certain mothers. Until they were shown to be obstetrically inadvisable, or economically or administratively impracticable, they should continue to be available. He noted that the MSAC had been unanimous in its support for hospital care for all mothers, but it was important to recognise that such care was in no way uniform. It varied according to hospital, individual consultant, time of day, etc., and before depriving women of their right to choose, it was important to ensure that the alternative care was indeed an improvement. As yet, the evidence for this does not exist.

The diminishing involvement of general practitioners in intranatal care in part reflected present day training programmes. Luke Zander's personal experience with trainees suggested that those who had undertaken Senior House Officer posts in obstetrics were often more reluctant and anxious about providing intranatal care than before they had experienced this period of training, as a result of the dependency they developed to the high technology in the modern labour ward. In a list of objectives for obstetric training for general practitioners, put together jointly by the RCOG and RCGP, there was no mention of management of the normal delivery; no mention of the pros and cons of induction, only the indications for its use; no mention of the indications for monitoring, only the principles and practice of doing it. The last objective listed was the ability to communicate with women in labour "so they understood the procedures proposed for their own safety". Communication, said Luke Zander, was not a matter of explaining what you were going to do, but a two-way exchange of views in an attempt to arrive at a mutually acceptable decision. Trust only comes when someone believes you will take notice of what they say.

* Klein M et al (1984). A comparison of General Practitioner and Specialist Delivery Services, in Pregnancy Care for the 1980s, by Zander, L. and Chamberlain, G. (Eds), Macmillan Press

Achieving change

Luke Zander felt that the conference was showing signs of complacency about introducing change in the maternity services. Change was about politics and power and inevitably involved conflict. The contribution from the City and Hackney CHC, he felt, had been very significant. Fundamental changes were unlikely to come from within the profession, but rather from pressures being exerted from outside. He noted that the recent major change in attitudes towards the position of the labouring mother had come about largely through consumer pressure following two widely publicized television programmes by a French Obstetrician, Michel Odent, and a large demonstration on Hampstead Heath of mothers objecting to the restrictions imposed on labouring mothers in a large London teaching hospital. A change in attitudes towards episiotomies had been stimulated by a study undertaken by the National Childbirth Trust which highlighted the fact that no significant study of this universally practised procedure had been undertaken by the profession.

That the consumer is the strongest ally for change demanded a major shift in understanding for many people, both within the profession and outside. Mothers, midwives, GPs and obstetricians who wanted change formed natural allies if they could recognise this; the agents of change would be the mothers.

The MSAC must be congratulated for clearly setting out what changes needed to occur. Luke Zander felt that an MSLC would be most likely to effect these changes if the chairperson was neutral and the discussion truly non-hierarchical.

Intrapartum Care: The Obstetrician's Perspective. Mrs. Wendy Savage, Consultant Obstetrician and Senior Lecturer in Obstetrics and Gynaecology, The London Hospital (Mile End).

Wendy Savage introduced her talk by saying that the most important people in intrapartum care were the midwives. This was particularly true in relation to obstetricians, for in practice, once qualified, obstetricians rarely appeared in the labour ward except to do deliveries for private patients.

Wendy Savage divided the obstetrician's role in the labour ward into four parts: organisation; training; presence and example; and monitoring.

1) Organisation

a) Labour Ward protocols: obstetricians and midwives should jointly work out policies and procedures for the labour ward. Staff did not need rigid rules but did need to know exactly what to do in any situation, eg rising blood pressure, need for anaesthetic, haemorrhage.

b) Deployment of staff: Wendy Savage welcomed the MSAC recommendation that the doctor on duty should have no other commitments. A doctor running an ante-natal clinic and being on call for the labour ward did neither job satisfactorily. The problem was resources. Obstetricians had historically worked impossible hours. The NHS did not see the reduction in birth rate as a way to lighten workloads on exhausted obstetricians-in-training but as an excuse to reduce staff. Only 3% of consultants were obstetricians and so obstetrics got squeezed by more powerful (interest) groups. Yet the quality of the next generation reflects the quality of care women receive in labour.

c) Establish working relationship with senior midwives: Lip service is often paid to the professional status of midwives but in practice midwives were often treated like handmaidens.

d) Equipment: should be available when needed. However, enormous sums had been paid out on fetal monitors yet they had been subject to proper controlled trials only in the last year. Obstetricians had to make sure equipment functioned properly to avoid unnecessary anxiety. And as a group they needed to pressurise firms into making more reliable machines. Wendy Savage felt the atmosphere in the labour ward was more important than curtains and carpets. Obstetricians should not get carried away by status symbols such as expensive birthing stools, when cheap ones could easily be made.

e) Gaining adequate support services: Access to paediatricians, anaesthetists and decent pathology facilities was essential. Social workers were vital too. Wendy Savage would also love to see psychiatrists involved in obstetric units because of the widespread incidence of psychiatric illness. Pregnancy and birth were times that seemed to facilitate change and opportunities were wasted in ante-natal clinics and during delivery.

2) Training

SHOs (both career obstetricians and GP trainees), registrars and midwives all need the same kind of basic training. One problem was that complications of pregnancy were so rare nowadays that teaching on the job is not always sufficient. An SHO might see only two mid-forceps deliveries in six months. More use needs to be made of teaching aids like videos, tape/slide programmes on, for example, how to interpret monitor traces. Consultants also need to keep up to date and should attend study days etc. Once appointed as consultants they rarely went on the labour ward, so that many consultants would be completely out of touch were it not for the existence of their private patients.

Drills

Young midwives and doctors may never see severe cases of eclampsia or post-partum haemorrhage during their training. There is a place for practice drills for these life threatening conditions. Otherwise young staff may be faced with decisions which are beyond their competence. Unless their anxiety is coped with, they become the wrong kind of obstetricians. In some units obstetricians are now doing labour ward duty. Specialist attendance is needed or else the nonsensical situation can arise that a woman is sent by a competent consultant from a District General Hospital to a hospital with intensive care unit, only to be seen by a registrar who has been in post two weeks.

e) Presence and example

Good obstetricians can bring about a lot of change through their presence on the labour ward. By virtue of their experience they can allay the panic and anxiety which strike fear into the hearts of women and their partners and make the labour ward jumpy rather than joyous and inspiring.

4) Monitoring and an annual review of trends

a) Monthly/weekly statistics: Obstetricians need to know if for example the forceps rate or caesar rate is rising in their unit and to find out why.

b) Perinatal meetings: are a great force for improving services, though it is important to recognise the emotional aspects of these meetings.

c) Case note reviews: are done every 24 hours in a well-known Dublin unit . It is a way of knowing what is happening in a department without always being present.

d) Formal staff training record: This should be kept for all grades of staff, and staff should see and comment on it as in the civil service. People need to know how their performance is seen by others.

Intrapartum Care: The Midwife's Perspective. Miss Joan Greenwood, Director of Nursing Services (Midwifery, Gynaecology and Ophthalmology), Paddington & North Kensington HA.

Joan Greenwood took as her brief the parts of the MSAC's report that most concerned midwives. She began by agreeing with Luke Zander and Wendy Savage on the paramount importance of the midwife in the labour ward. Midwives should not play the nurse's role of giving and protecting. Midwives should stand back, support, educate and counsel, helping the woman to give birth the way she wanted.

Operational policies

The MSAC wanted clear operational policies for the labour wards. Basic protocols would free midwives to concentrate on care instead of worrying about what procedure they should be following. Operational policies would reduce confusion among doctors and midwives (who worked different lengths of time), and among all the trainees, but they would also mean that all consultants working in one unit had to agree on what staff should do. Joan Greenwood thought midwives should not have to tolerate the situation where they did one thing one morning for one consultant and something different in the afternoon for another.

Protocols increased safety because women got the right level of care when staff understood exactly what they had to do.

A registrar and a sister were good people to get to write a protocol then it was not seen as coming from the top downwards. The protocol should then be approved by the consultants and senior midwives before implementation.

Home confinements

Because of divisions within the service, however hard the individual GP, midwife or consultant worked, the experience of the mother who wanted a home birth was often incomplete, fragmented, unsatisfactory and wildly irritating. Because of different problems in different Districts the MSAC had felt unable to do more than give a clear definition of where responsibility lay for home confinements. The statutory duties of the Supervisor of Midwives were mentioned. And the MSAC put the onus on Health Authorities and MSLCs to decide what service to provide.

Changes in attitudes

Joan Greenwood challenged staff at the conference on their attitudes. Was their service being run for the doctors, the midwives, the learners or the mothers? Under any circumstances in the labour ward could they honestly say "we are working for the mother"? 300 women waiting in an ante-natal clinic were a clear indication that the service was being run for the doctors. The MSAC proposal of one midwife per mother in labour might not sound much but in practice was very difficult to achieve. But had people even attempted it?

Joan Greenwood read out a letter from a woman who wrote "I've been looking into the possibility of an active birth ... I'd like to move around freely during labour, I'd like to choose whatever position is comfortable, I'd like the baby given to me immediately after the birth, ...(and she gave a whole list of what she wanted to happen at the birth). The letter ended "I am being careful to ensure that I am in good health and well prepared and am therefore concerned to make sure that my baby and I have the best possible birth experience. I do not wish to appear either aggressive or dogmatic, but I would like to make this experience as pleasant as possible".

Joan Greenwood asked how people felt when they received such letters. Did they try and send the woman elsewhere, or think of a particular midwife who could deal with this 'difficult' kind of mother, or could their staff say 'yes' to most of these things?

The capacity to be caring came from the confidence people had in their own capabilities and role, trusting themselves and therefore being able to cope with the demands made on them. We call ourselves the caring professions, said Joan Greenwood. Do consumers see us like this?

Questions and Discussion

Professor Hibbard said it was sad that women felt they had to write such letters to get what they wanted. Janet Jennings, a CMW from Islington, said that a birth plan should be discussed with every woman in the ante-natal clinic. Wendy Savage said that birth plans should not become yet another way that professionals controlled women.

Ms Hazel Rawlinson, a consultant from Wolverhampton, said women needed birth plans, but also needed to be flexible. Following a bad experience, she would now get women who did not want a Caesarian under any circumstances to sign a letter to this effect. Joan Greenwood said that flexibility was called for on both sides. Women became fixed in their ideas because they were not offered a dialogue. Hanna Corbishley from NCT said birth plans were not just for normal labours, and should contain contingency plans. Wendy Savage said professionals did not like the time all the communicating took. Nor did they like to hand over knowledge, especially when they were not certain about it themselves. Luke Zander agreed it was a question of control and power over information and would not duck that issue.

Preparation for Childbirth: Voluntary Action. Hanna Corbishley, National Secretary, National Childbirth Trust.

Hanna Corbishley talked about mothers' feelings about birth. The unspoken message to the mother in a technological birth was that her womb was not good for the baby and the sooner the baby was out of the womb, the happier that baby would be. It was no wonder that mothers felt humiliated and angry. Birth is a highly charged emotional experience for women and women intuitively know what they want from it. In the past obstetricians did not realise what these feelings were, but things were improving.

NCT recognised how awkward some mothers were. Some came to NCT classes with their minds fully made up. NCT teachers tried hard to get mothers to be realistic. It was very hard for an obstetrician after 20 years service to be told he was doing things all wrong. However, not all consumers were critical and many were grateful for improvements in maternity care. Nevertheless, in childbirth it is the mother's body and the mother's baby and she will have responsibility for that young life. Women in childbirth should not be treated as though they had come into hospital to have their appendix out.

As obstetricians were losing confidence, women were gaining it. This was no bad thing for it made obstetricians consider the mothers more. And it led to dialogue. NCT was an educational trust and service-providing agency, not a pressure group, and had always tried to talk with health professionals. She could quote a local group though who had worked incredibly hard to prepare a study day which no obstetricians had bothered to attend, though many midwives, some students and some registrars had come.

Health professionals had to talk to women just as women had to talk to professionals. MSAC had made this much easier, especially through the MSLCs. Dialogue was improving as everyone tried harder. NCT thought the MSAC's work was tremendous, and that the groundswell for change had come from the consumer. She quoted a birth report from a local NCT branch newsletter. The writer had had two "technological" births and had felt a good birth experience was not possible in hospital. But when her sister-in-law gave birth a few years later the atmosphere in the hospital had totally changed. The midwife was relaxed and supportive. The mother had been helped to give birth the way she wanted. Hanna Corbishley felt this was the trend all over the country.

Some women, however, would still prefer a home birth. Because mortality and morbidity rates had seemed to imply that home births were unsafe, these had been phased out. More recent research suggested that planned home births had an excellent safety record. Previous statistics had included accidental and unplanned home births, which certainly posed great risk, especially to very young mothers who had received no antenatal care and had told no-one of their pregnancies. For these, the availability of an obstetric flying squad, as recommended in the MASC report, would continue to be vital. These squads had been run down in many areas, because home births had been phased out, but the real risk lay in unplanned births and these would go on needing emergency obstetric services.

Finally, Hanna Corbishley presented a plea for significant reduction in routine technological intervention in childbirth on safety grounds in hospital. Two thirds of babies who died at birth (perinatal mortality rate 10.4 per 1000 total births) did so because they were of low birth weight, and there was nothing any obstetrician could do at birth to make a baby heavier and thus more able to survive. 996 women suffered unnecessary and humiliating procedures for the sake of the 4 unfortunate mothers whose pregnancies could usually be picked up as high risk in any case. As low birth weight was the most significant killer of babies, it would seem more sensible to contain expenditure on increasingly sophisticated electronic gadgetry in the delivery room and to increase resources available for prevention and good pre-pregnancy counselling, so that women could afford to eat a nourishing diet, would know what this was, and how it related to fetal development.

Questions and Discussion

In the discussion, Mrs. Hurley, a Midwifery Nursing Officer from Bristol, stressed the needs of the individual mother. Pressure groups did not represent all mothers.

There was a sharp exchange of views on professional responsibility. Dr. Selwyn Crawford, a consultant anaesthetist and member of MSAC said that in the end obstetricians had to carry the can when things went wrong. Neither mother nor baby was nowadays expected to die and pressure from voluntary groups was promoting defensive medicine. Midwives present accepted that in hospital doctors carried legal responsibility, but many emphasised that midwives could lose their jobs through disciplinary proceedings by their professional bodies. They also pointed out that GPs did not <u>have</u> to attend home births but midwives did. Dr. Lyle said that trust and communciation were everything and that professionals had to look beyond a mother's list of demands to ask what they meant. Professionals needed to increase their understanding of people's feelings in emotional situations.

Alison Munro asked members of the conference their views on minimum standards. The MSAC had set out what was good practice since they felt local circumstances varied so much. The conference largely agreed with her on this point and speakers told of problems in laying down specific numbers.

On MSLCs, the problem of consultant reluctance was raised. Professor Hibbard said consultants were reluctant to talk, for instance, about statistics with CHCs. His MSLC had therefore started out on the topic of how to help bereaved parents which was non-controversial. Later, a study day on statistics had been organised.

Ruth Evans summed up by reminding the conference of some of the issues that had seemed important to her. She felt everyone concerned about maternity services should be out lobbying for more resources and not worrying about other peoples' departments. Along with resources to help those at risk, resources were needed to prevent people being at risk at all. This involved an integrated approach, not just pre-pregnancy self-help, but income maintenance, school dinners and so on.

The conference had stressed the role of the midwife as a professional in her own right. Doctors and midwives had their own very separate areas of responsibility that carried equal significance and weight.

MSAC had tried to achieve more trust and communcation between users and providers of services. There was a conflict between consumers who wanted to use stridency for change and those who wanted to use informed debate. A bit of both was necessary. Obstetricians' fears of strident consumerism and their sense of not getting credit for their work showed the need for both sides to think more of the merits of the other.

Because of the dramatic overall fall in perinatal mortality rates there was a tendency to forget how much more there was to do about class and race inequalities. These were the most important issues for MSLCs to confront. Ruth Evans hoped that the DHSS would remind the Regions to monitor the introduction of MSLCs in their Districts.

KING EDWARD'S HOSPITAL FUND FOR LONDON

King's Fund Centre

MATERNITY CARE IN ACTION - INTRAPARTUM CARE

Conference on Thursday 26th July 1984

Attendance List

Dr M S I ASHRAFF	District Medical Officer	Dewsbury HA
Miss G BALFOUR	Professional Officer	Royal College of Midwives
Mrs A BAMFORD	Senior Midwife	Ipswich Hospital
Mrs M J BEACOCK	Nursing Officer, Midwifery	General Hospital, Scunthorpe
Dr M BERKELEY	Specialist in Community Medicine	Grampian Health Board
Mr C N BOURNE	Member	Oldham HA
Ms B A BROADBENT	Member	Tameside & Glossop FPC
Mr M BROWN	Secretary to	Maternity Services Advisory Committee
Dr M A CARMI	General Practitioner	Enfield
Mrs A CARROLL	Asst. Director of Midwifery Services	Oldham & District General Hospital
Dr W CARSWELL	Consultant Obstetrician	Oldham & District General Hospital
Dr T A CHOUDHRY	General Pracititoner	Milton Keynes
Mrs A J COATES	Matron	Dilke Hospital, Gloucester
Mr D J COMMON	Deputy Administrator	Stepping Hill Hospital, Stockport
Ms CONWAY	Midwifery Tutor	Gloucester Maternity Hosp.
*Mrs H CORBISHLEY	National Secretary	National Childbirth Trust
Miss M COTTRELL	Clinical Manager	Milton Keynes General Hosp.
Dr J S CRAWFORD	Consultant Anaesthestist Member	Birmingham Maternity Services Advisory Committee
Mrs C CUTTS	Asst. Director of Nursing Services (Midwifery)	Stepping Hill Hospital, Stockport
Miss A DAVIES	Consultant in Obstetrics and Gynaecology	Sunderland District General Hospital
Miss P B DIXON	Director of Midwifery Services	Birch Hill Hosp. Rochdale
Ms C ECCLESHARE	Maternity Unit Administrator	University College Hospital
Mrs P M EGERTON	Senior Midwifery Tutor	St. John's Hosp. Chelmsford
Mrs H M EMES	Director of Nursing Services (Midwifery)	Good Hope Maternity Hosp. Sutton Coldfield
*Ms R EVANS	Coordinator	Maternity Alliance
Mrs M G FISHER	Member	Shropshire CHC
Ms S FLEETWOOD	Chairman	Liverpool Eastern CHC

Mrs H FRASER	Nursing Officer Midwifery	General Hospital Scunthorpe
Dr H R GAMSU	Reader in Neonatal Paediatrics Member	University of London Maternity Services Advisory Committee
Dr F N GARRATT	District Medical Officer	Wolverhampton HA
Miss E A GEE	Director of Midwifery Services	Luton & Dunstable Hospital
Ms W H GIEDKE	Senior Midwife (Labour Ward)	Whittington Hospital
Ms A M GILLARD	Head of Midwifery Services	Royal Sussex County Hosp.
Mrs J GOUDIE	Director of Midwifery Services	Princess Mary Mat. Hospital
Dr R GRAHAM	Specialist in Community Medicine (Child Health)	Richmond, Twickenham & Roehampton HA
*Miss J GREENWOOD	Director of Nursing Services (Midwifery, Gynaecology & Opthalmology) Member	Paddington & N. Kensington HA Maternity Services Advisory Committee
Miss F A S HAINES	Principal Nursing Officer	Queen Charlotte's Chichester HA
Dr A S HARRIS	District Medical Officer	Chichester HA
Miss J HATCHARD	Asst. Director of Nursing Services	Royal Berkshire Hospital
Prof B M HIBBARD	Professor of Obstetrics and Gynaecology Member	Welsh National School Medicine Maternity Services Advisory Committee
Miss M R HITCHCOX	Nursing Officer - Labour Ward	Southlands Hosp. W Sussex
Mrs A V HOLDSWORTH	Nursing Officer	District General Hospital Eastbourne
Miss M HOOPER	Nursing Officer - Labour Ward	Pembury Hospital
Dr J HUNTINGTON	Fellow in Organisational and Professional Studies	King's Fund College
Mrs M E HURLEY	Nursing Officer - Community Midwifery	Chipping Sodbury Hospital
Mrs P INCE	Acting Head of Midwifery Services	Royal Cornwall Hospital
Miss J M JAMES	Director of Midwifery Services	Hillingdon Hospital
Miss J K JARDINE	Director of Nursing Services (Midwifery)	Princess Margaret Hospital Swindon
Mrs J JENNINGS	Representative	Radical Midwives Group
Miss A M JUDSON	Asst. Director of Nursing Services (Paediatrics,Midwifery,Gynaecology) Member	Leeds Western HA Maternity Services Advisory Committee
Mr W B KIRWIN	Member	Bolton HA
Mr D LEESE	Administrator (Acute & Midwifery)	Good Hope Maternity Hosp. Sutton Coldfield
Dr J LEESON	District Medical Officer Member	North Manchester HA Maternity Services Advisory Committee
Dr R C H LYLE	General Practitioner	Lower Clapton Health Centre

Mrs N McCALL	Director of Nursing Services (Midwifery)	Bolton General Hospital
Mrs S McCRINDLE	Midwifery Sister	District General Hosp. Eastbourne
Mrs B B MacLENNAN	Director of Nursing Services	Glasgow Royal Maternity Hos.
Ms L MARTIN	Nursing Services - Midwifery	St John's Hosp. Chelmsford
Ms H E MATTOCKS	Asst. Director of Nursing Services (Midwifery)	Farnborough Hospital
Dr J S METTERS	Senior Medical Officer	D H S S
Miss I MILNER	Nursing Officer (Maternity Dept.)	Hinchingbrooke Hospital
Mrs C M MORRISON	Director of Nursing Services (Midwifery)	Basingstoke District Hospital
*Mrs A MUNRO	Chairman Chairman	Chichester Health Authority Maternity Services Advisory Committee
Ms L MURRARY	Director of Nursing Services (Midwifery)	St. George's Hospital
Miss H NEWTON	Head of Midwifery Services	Pilgrim Hospital, Lincs.
Ms C NIGHTINGALE	Director of Midwifery Services	Hinchingbrooke Hospital
Ms Y NOWELL	Midwifery Superintendent	Airedale General Hospital
Ms J NUGENT	Asst. Director Midwifery/ Paediatric Services	St. Helier Hospital Carshalton
Miss J PLUNKETT	Senior Assistant Director	Ashington Hospital
Miss B K RAI	Senior Midwife Teacher	Basingstoke District Hosp.
Miss H M RAWLINSON	Consultant Obstetrician (Gynaecologist)	New Cross Hospital Wolverhampton
Ms RHODES	Member	Hillingdon CHC
Mrs G RICHARDS	Director of Nursing Services (Dover/Deal Unit)	South East Kent HA
Dr J D RIDDELL	General Practitioner	Highgate, London
Ms J M RIDYARD	Director of Nursing Services (Midwifery/Gynaecology)	Scunthorpe General Hospital
*Ms H ROSENTHAL	Member	City & Hackney CHC
Dr C J ROWLAND	G P Obstetrician	Surrey
Mrs H RUTT	Vice Chairman	North West Herts CHC
Miss L D SALISBURY	Nursing Officer	Gloucester Maternity Hosp.
Mrs G SANDIFORD	Senior Midwifery Tutot	Oldham & District General Hospital
Mr J R SAUNDERS	Consultant Obstetrician and Gynaecologist	Bedford General Hospital
Ms A SALFIELD	Information Officer	Maternity Alliance
*Mrs W SAVAGE	Consultant Obstetrician and Senior Lecturer in Obstetrics & Gynaecology	The London Hospital
Dr P SCHATZBERGER	G P Obstetrician	Birley Moor HC, Sheffield
Mrs R M SCOTT	Director of Midwifery Services	QE II Hospital, Herts.
Mrs A M SHERMAN	Asst. Director of Nursing Services (Maternity)	St Marty's Hospital Portsmouth

Mr P SHRIGLEY	Administrator - Hosptial	Derby City Hospital
Dr B A SIDES	General Practitioner	Manchester
Mrs A M SLATER	Patient Services Officer	Birch Hill Hospital Rochdale
Ms B D SMITH	Asst. Director of Nursing Services (Midwifery)	Derby City Hospital
Ms D M SPARY	Nursing Officer	County Hospital, Hereford
Dr G W TAYLOR	General Practitioner Member	Reading Maternity Services Advisory Committee
Mr J THOMLINSON	Consultant Obstetrician and Gynaecologist	Staincliffe Maternity Unit West Yorkshire
Mrs P H TORR	Clinical Manager	Milton Keynes General Hosp.
Dr M TOWNSEND	Community Physician (Child Health)	Stockport HA
Ms T TURNER	Rapporteur	King's Fund Centre
*Miss F WALLACE	Member	City & Hackney CHC
Ms S WARSHAL	Representative	A.I.M.S.
Dr E WEBSTER	General Practitioner	Newbury Park HC, Essex
Miss M WEST	Clinical Nurse Manager	Royal United Hospital, Bath
Mrs K WHITEHOUSE	Member	Wolverhampton HA
Ms E WILLIAMS	Nursing Officer	County Hospital, Hereford
Dr M R YOUNG	General Practitioner	Steels Lane HC, London
*Dr L ZANDER	Senior Lecturer Department of General Practice	St. Thomas' Hospital Medical School

* denotes speaker