Soo Downe: The Storyteller
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Of all the midwives in all the world, Soo Downe may be one of the least likely to have wound up in the profession at all. A whimsical speaker whose reflections shift between academic terminology and no-nonsense brass tacks, her capacity to spin a story is enchanting. And no surprise, either: having studied Literature and Linguistics, Soo’s vocation of midwifery came after a totally unexpected ‘Road to Damascus’ experience during a week working in a maternity unit in apartheid-era South Africa – a story (she says to my disappointment) for another time.

“It was a complete transformation,” she says, effervescent in her enthusiasm even after all these years, “I felt like if we could get birth right, we could get the world right.”

After some years working as a clinical midwife on a busy labour ward, she had many questions that she felt needed to be asked. At this point, she wanted to be a research midwife, but in the early 1990’s in the United Kingdom, the concept did not really exist. After 15 years working in the National Health Service, during which the philosophy of midwifery continued to enchant her, Soo moved into a higher education system that was now ready to cultivate the curiosity of clinical practitioners like her. When speaking of qualitative research, Soo comes truly alive: her enthusiasm is contagious as she describes how human-oriented research has changed otherwise impersonal models of health care structure and provision.

“I really like to combine storytelling with research because audiences respond to stories,” Soo says. “Qualitative research is one way to capture stories systematically – it has become much more acceptable to the mainstream. Researchers are increasingly aware that interpretation of data is a kind of story, but that, in academic research, you have to be clear about ensuring the story is rooted in the data. This is not the same as telling an individual story. One of the reasons the World Health Organisation (WHO) now have guidelines for positive antenatal and intrapartum care is partly because, with the support of the WHO leads for the guidelines, we presented qualitative data from women to the WHO guideline development group and they saw women’s stories reflected in the data. This completely changed the tone of the discussions, and influenced what was seen to be important about the recommendations made.”

Soo, who co-authored “The Roar Behind the Silence: Why kindness, compassion and respect matter in maternity care” alongside Sheena Byrom, mentions the aforementioned values often. The kind of research she does requires substantial transparency and trust from the women and families she works with, and it is clear that this responsibility to do these people justice influences every story that is told about the research: the good, the bad and the tragic.
“There’s an ethical obligation in this kind of storytelling to make sure the stories that emerge from research are rooted in – well, perhaps not absolute truth, since that’s a fluid concept – but reality,” Soo says, “Storytellers can make people believe the most extraordinary things. There’s an ethical imperative to make sure stories are told compassionately, authentically, and, if they are about formal research, with constant reference to the underlying data.”

The preservation of dignity is important to Soo. Aware of how easy it is to slip into hyperbole, she makes a point of checking with the source of any story whether it has drifted from the initial telling, to make sure that has not drifted from the initial telling. She also tries to maintain the delicate balance of talking positively about childbirth in a world that loves a bad news story – without diminishing the need for balance between both the joyful and the tragic, and keeping women at the centre.

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“It’s the classic archetype of the Heroes’ Tale,” she says, “Women should be the hero in their own story – and particularly in stories of birth. This is important because women are rarely cast as heroic. Even in tragic situations, we need to acknowledge that some women feel they have grown as a result of the experience. How do you acknowledge the depth of the tragedy without catastrophising it? It is possible for a woman to go through birth experiences that take her to the very edge of her capacity, and for her to emerge as something different, something more... without being scarred by the experience, if she has good support and care, from family members, and from midwives (and where needed, doctors and others), at every stage of the process.”

The term ‘normal birth’ is one that many midwives staunchly defend because it empowers women to trust that their bodies are designed to labour and birth as a normal physiological process. However, a linguist can always be relied on to focus on the specific verbiage, and Soo is no exception.

“Some professionals consider a birth ‘normal’ even if it has had every intervention under the sun minus caesarian section,” she says, “Many women who experience multiple interventions perceive their birth as traumatic, especially if they were not supported by professionals, or if they also experienced labour as uncontrollably painful. Despite the trauma, if they give birth vaginally, they are still told their births are ‘normal’. It is hardly surprising that, having experienced this, these women do not want such a ‘normal’ birth next time and they tell stories of their trauma to their pregnant friends. These women then also do not want this kind of birth, and choose a cesarean section or an early epidural as protection.”

Some service user groups argue that using the term ‘normal birth’ means that women who need or seek interventions, as well as those who are exposed to them unnecessarily in the name of risk reduction, are all somehow intrinsically ‘abnormal’. But, Soo says, this is to make the error of mistaking the events that happen for the person they happen to. The complexity is understandable, and Soo emphatises
with groups who advocate against the terms ‘normal’ and ‘abnormal’ on this basis.

“Many women experience interventions they or their baby don’t need, or they do not feel supported when they do need interventions for themselves, and/or for their baby. Some of these women go into their first labour and birth with blind faith that everything we and our colleagues do will be for the best, but, for many, the interventions and attitudes they are exposed to in the name of risk reduction get in the way of their capacity to give birth positively. If women have previously experienced a birth called ‘normal’ that has left them feeling traumatised – or if they have heard stories of such births being considered ‘normal’ – it is hardly surprising that they demand interventions like elective caesareans; they don’t really feel they have any other viable options. And if they have been exposed to a range of interventions that make their birth ‘abnormal’, they don’t want to feel that they have failed to do birth ‘properly’. To reduce this, it is really important that midwives are able to act as active advocates for circumstances in which women are able to labour and birth physiologically, powerfully, and joyfully, as far as they possibly can, and where – if interventions are needed – they can be experienced as helpful and empowering.”

During pregnancy, women are under heavy surveillance and subject to tests and treatments, which can lead them to believe that they cannot trust the baby is safe unless (for example) they receive ultrasounds at every opportunity. Soo believes that stories should be used to explain and challenge this approach.

“Sometimes women and babies need interventions – caesarians are lifesaving when needed, and epidural analgesia can be a profound relief for women experiencing unrelieved labour pain – but when these kinds of intervention become a ‘just in case’ norm, they can be harmful”, she says, “To counteract this effect, we tell positive birth stories, of joy, love, achievement and transformation. These include stories of women who labour and give birth normally with authentic and dedicated midwifery support, as well as those who have had some complications and who may have needed drugs, a drip or a caesarean, but who have been enabled by the support and encouragement of midwives and others to achieve as positive a birth as possible. If we enable a woman to do as much as she can herself whilst we do what we must to ensure the woman and baby are safe, we increase the chance of her having a positive labour and childbirth, and we maximise the opportunity for her to become a become confident and competent mother.”

In light of global discussions to reduce unnecessary caesarean sections – an initiative supported by the World Health Organisation (WHO), the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) – the question of what solutions should be put in place are prudent.

“There’s a huge global push to reduce caesarean section rates to reduce short and longer term iatrogenic morbidity, but the proposed solutions often seem to be more interventions, such as routine induction of labour at
39 weeks’ gestation,” says Soo, “This solution itself is expensive, and many women don’t want to be induced (though some do) because it has potential for long-term adverse side effects for both mother and baby. It’s not that people want to do wrong by women and babies, it’s that they’re framing the solution in terms of what will help the few, but that could harm the many. The alternative is to look for solutions that are low cost, sustainable, and have no known or likely long-term adverse effects. For example, continuity of midwife-led care in pregnancy and during birth improves rates of normal birth, and women’s wellbeing. Similarly, companionship during labour reduces rates of caesareans, and is less expensive than routine induction of labour. However, a turn towards these kinds of inter-personal, social, midwifery solutions demands a seismic ideological shift.”

An ideological change of this nature is so immense as to be intimidating, but Soo believes it can happen.

“We’re trying to recount stories that say that maternity care should be framed around BOTH (safety) AND (positive wellbeing) for women, babies, and families throughout the maternity episode, rather than seeing it as a choice between EITHER ensuring safety (mainly of the baby), OR enabling women to have a positive experience,” she says, “If we can use storytelling to change the way maternity care is thought about and provided, towards this ‘both-and’ philosophy, staff, women, families, and the public will demand a different approach. They will reclaim ways of providing maternity care so that it is both a safe and a life-enhancing experience. The evidence shows that what matters most to pregnant women is to have a healthy baby, a normal experience of labour and birth, and the capacity to mother effectively. The stories we tell are about women who are not just satisfied with labour, but who have a hugely positive and enjoyable experience, even if there are problems, so they can reclaim their self-belief as heroes, and maximise their capacity to effectively mother their children.”

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