AIMS JOURNAL

To Induce or Not To Induce

At least ask the Question

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AIMS

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Editorial

Induction: Indispensable or Epidemic?

by Journal Editors, Kate Hickey and Emma Ashworth

'Speed Them Up'. Kindly donated for AIMS' use by Susan Merrick

Can there simultaneously be too much and yet not enough of something? It seems, when it comes to induction, that yes, there can be.

The *AIMS Helpline inbox* is frequently filled with emails from women who are telling us about the coercion that they are receiving from their doctor or midwife, pressure to be induced with little or no explanation – or, worse, *the 'dead baby card'*. At the same time, we also get vast numbers of emails from women who are not being listened to when they try to tell their health care provider that they are worried about their baby.

With the national induction rate at 32.6% (2017–18) many of us are extremely worried about the recent sharp increase and the potential consequences this has for women and their babies. How have we got to this situation? What are the benefits and risks to having so many induced births in the UK? Do women know they have the power to refuse an induction if it is offered and do they know what questions to ask?

This Journal attempts to make a start at unpicking the good, the bad and the ugly that is induction. We evaluate research, how it is applied in the real world and how it affects women and babies. Katie Hickey has investigated the care bundles that are trying to reduce the numbers of babies who are lost to stillbirth – induction being front and centre of the proposed solutions, with the assumption that babies are 'better out than in'. Ann Roberts digs into the 35/39 study which has led to women in their late 30s and 40s being strongly encouraged into induction, and Gemma McKenzie reviews some research into women's experiences of induction. Sadly lacking in so much research, the way that induction affects women and babies must be brought to the centre of any ongoing studies.

We know that women who are induced are often denied access to water, while still being offered heroin (diamorphine) or an epidural with all its associated risks. Dianne Garland and Emma Ashworth share their research into how water can be used during any form of induction to help women to enjoy a better experience, and hopefully to provide support for more movement, reducing the chance of adverse outcomes associated with epidurals where the woman is confined to a bed. And to show that induction can be a wonderful experience for some, we welcome Jay Kelly's birth story: her favourite birth was an induced birth!

We feel that the article by Debbie Chippington Derrick and Nadia Higson, who have evaluated the data reported by MBBRACE (previously CMACE) may leave many needing to rethink their assumptions. Their conclusion? That the risk of stillbirth for women who have waited for birth beyond 42 weeks appears to be LOWER, not higher, according the MBRRACE data and that from earlier confidential enquiries.

As well as our themed articles we would like to thank our contributors for their invaluable contributions which include articles on supporting visually impaired women around pregnancy and birth, an update on the homebirth situation in York and an account of Beth Whitehead's search for justice following her assault in birth. As always, if you have an article to offer which hasn't been published elsewhere, please do get in touch with us via journal@aims.org.uk.

We hope that you enjoy this edition of the AIMS Journal. The AIMS Journal is supported by AIMS Membership subscriptions and the work of AIMS could not continue without the support of our Members. We would be delighted if you would consider joining AIMS as a Member (https://www.aims.org.uk/join-us).

Article

Labour Induction at Term

How great is the risk of refusing it?

By Debbie Chippington Derrick and Nadia Higson

It is very common for women to be told they need to have their labour induced before 42 weeks because otherwise they are at increased risk of stillbirth. Here we look to see whether the evidence actually supports this belief.

There are different types of evidence that might help us answer this question, but unfortunately this evidence is contradictory, and there has been much contention about whether induction of labour should be offered to women purely on the basis of longer pregnancy. Term birth is defined as a birth that occurs anywhere between 37 and 42 weeks of pregnancy, with births after 42 weeks being classed as 'post-term'. However, induction of labour at some point after 40 weeks of pregnancy has been routinely carried out by some in obstetrics since the 1970s.

Definitions used in this article

'*Stillbirths*' refer to deaths that occur before birth. They can be subdivided into antepartum stillbirths (which occur before the start of labour) and intrapartum stillbirths (where a baby was alive at the start of labour but shows no signs of life at birth and cannot be resuscitated).

'*Neonatal deaths*' are where babies who were born alive die in the first week of life.

'*Perinatal deaths*' are the total of all stillbirths and neonatal deaths.

It is normal to give rates of stillbirths and perinatal deaths as deaths per 1000 births, whilst neonatal deaths are given as per 1000 live births.

What do the guidelines say?

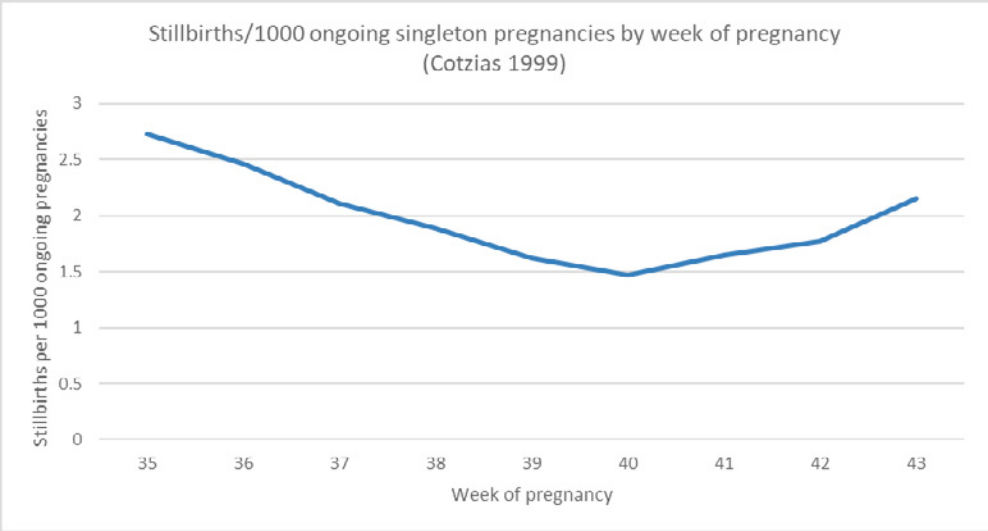
The NICE Guidelines on Induction of Labour[1] and the update[2] both recommend that induction is offered between 41 and 42 weeks of pregnancy, stating that there appears to be a reduction in perinatal deaths with induction of labour at this point, compared with waiting beyond 42 weeks. The NICE update mainly bases this on the Cochrane review[3] . There has since been another Cochrane review[4], which has the same conclusion, and we can expect the NICE guidelines that will be published in July 2020 ~~this year~~ to repeat this information and the recommendation for induction purely on the basis of longer gestation. However, these reviews do acknowledge that the risk of stillbirth appears to be very low in longer pregnancies and the later one suggests it would be necessary to induce 426 women at around 41 to 42 weeks to avoid one stillbirth.

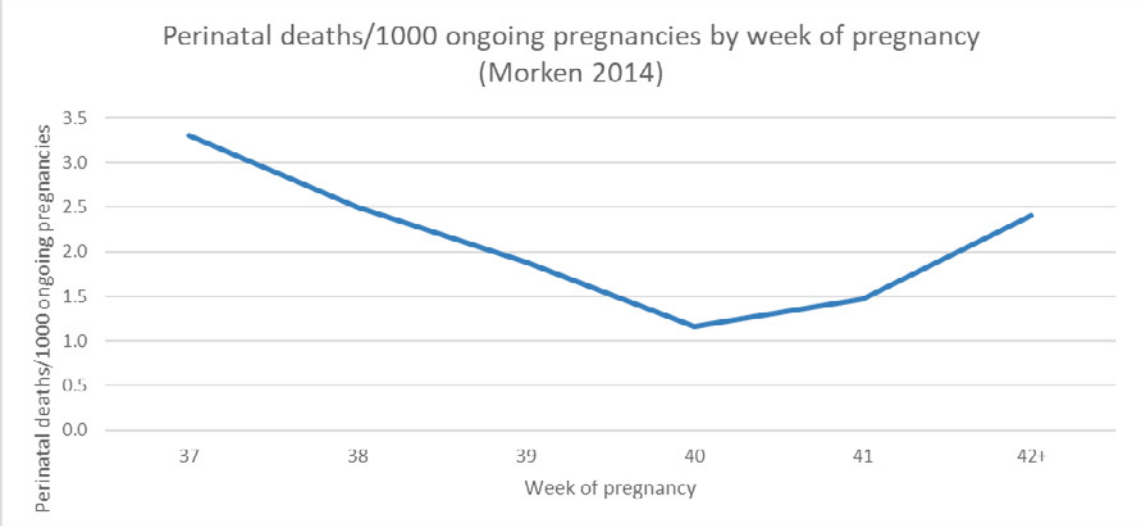
Types of research

The Cochrane reviews are what are called 'meta-analyses', which combine the data from a number of research trials. One problem with this type of review is that the results can vary depending on which trials the authors choose to include. Other reviews that have addressed the same question have reached different conclusions. For example, one that looked only at studies of induction at 41 weeks or beyond found no evidence that this was beneficial[5]. Another, which included only trials published since 1990, found no significant difference in perinatal mortality whether labour was induced before 42 weeks or not[6].

Population studies

Another type of information comes from population studies, which looked back at the records of outcomes for mothers who gave birth at different gestations. Although it's true that some of these have shown a rise after 40 weeks in stillbirth rates[7] or perinatal death rates[8] (which include stillbirths and deaths in the first week of life) [Morken 2014], the risk remains low, and is no greater at 42+ weeks than it was at 37 weeks. The two graphs below show the data from these studies.





UK Confidential Enquiries

Most years since 2005 the UK Confidential Enquiries have reported on the data collected from the 20,000 or so women whose pregnancies have continued to week 42 or beyond and these mothers have provided us with a more recent UK-based population study. This current article is based on an update of the detailed analysis of this data previously published by Margaret Jowitt[9].

The Confidential Enquiries enable us to look at how the outcomes of post-term pregnancies compare with the outcomes of pregnancies where birth took place between 37 and 42 weeks. The last 10 Confidential Enquiry reports, from between 2005 and 2016, have consistently shown that the risk of stillbirth and neonatal death is *lower* for mothers who birth beyond 42 weeks than it is for all those who birth at term.

The UK has made concerted efforts to bring down the perinatal mortality rate since 1991 when the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) was set up, and rates have steadily declined. The Confidential Enquiries look at some cases in greater detail to try to tease out common factors in stillbirths and neonatal deaths. They look at factors such as maternal age, ethnicity, birth weight and length of gestation. CESDI reporting was combined with the Confidential Enquiry into Maternal Death to become CEMACH in 2003 and from 2006 was renamed CMACE and run by the RCOG. In 2012 the contract for the work went to the National Perinatal Epidemiology Unit in Oxford and was renamed Mothers and Babies, Reducing Risk through Confidential Enquiries (MBRRACE-UK), leading to a gap in reporting, and therefore no reports for2010 and 2011.

The Confidential Enquiries provide data for the whole of the UK giving numbers of stillbirths (which since 2014 have been broken down into antepartum stillbirths and intrapartum stillbirths) and of neonatal deaths.

Induction of labour at some point before 42 weeks of pregnancy is being offered in an attempt to prevent antepartum stillbirth. In situations where this happens, no one – parents or health care providers – can avoid the feeling that if only labour had been induced earlier, these babies might have lived. Antepartum stillbirths outnumber intrapartum stillbirths by a factor of 10:1 and so it is thought that the greatest scope for reducing the stillbirth rate is by inducing labour earlier. Whilst this may appear logical, we need to consider whether this recommendation is supported by the evidence. Women are often put under pressure to accept induction, particularly at 41 weeks and certainly as they approach 42 weeks. Induction, however, is not without risk for both mother and baby[4, 10].

Even when trials are pooled in a meta-analysis such as the Cochrane reviews mentioned above, the numbers of births included in these studies are still very small compared with whole population statistics. In contrast, the huge numbers of births included in the data collected by MBRRACE-UK and its predecessors can help to give a clearer picture of the issue. While these statistics cannot provide an answer to the question as to whether induction protects against stillbirth, they do provide clear information about how many stillbirths and neonatal deaths occur in pregnancies in the UK that continue beyond 42 weeks, and give a comparison with the rates for pre-term births (before 37 weeks) and at term (between 37 weeks to 41 weeks + 6 days).

Data from MBRRACE-UK and its predecessors

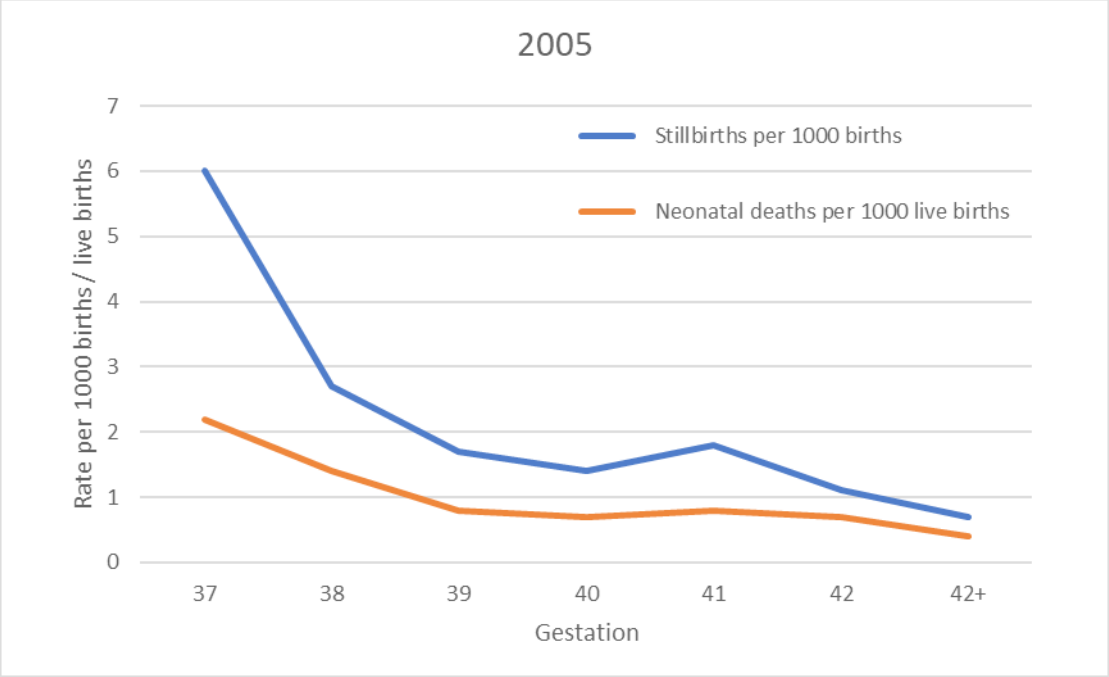
The table on the following page provides the data from the reports between 2004 and 2016. The data collected and how it is presented has changed over the years. For example, in some years, details for each week of gestation were given, whilst other reports gathered together the data for several weeks. Nevertheless the data still tells the same story.

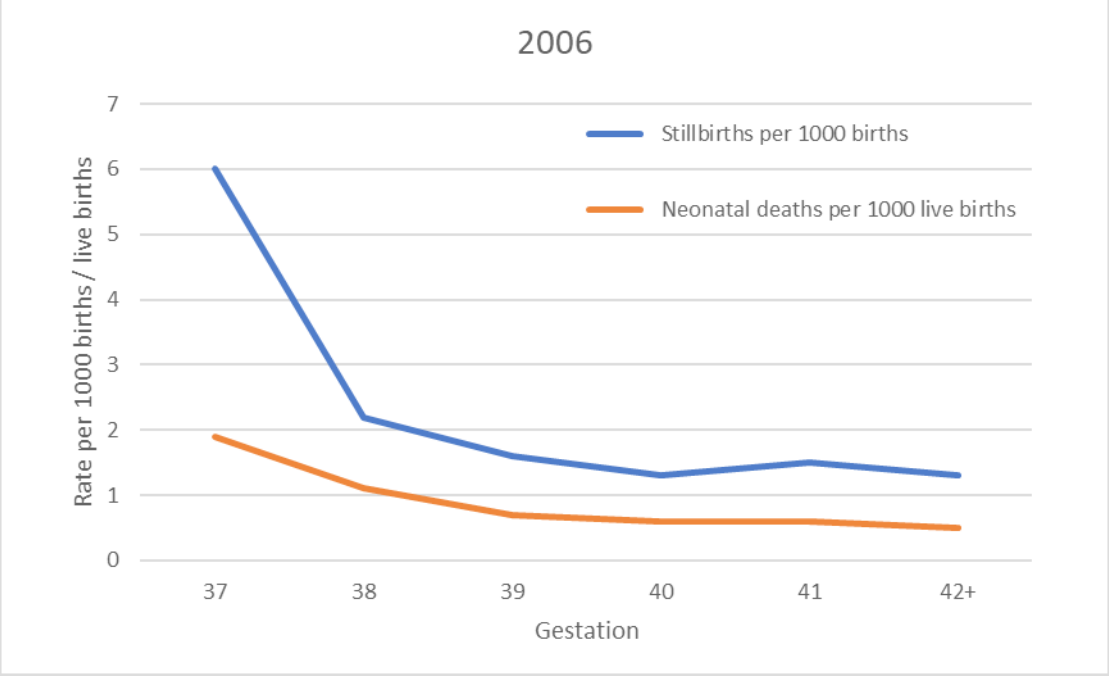
It can be clearly seen that none of the Confidential Enquiries reports support the statement that the risk of stillbirth increases with advanced gestation; on the contrary, the tables all show that the risk of both stillbirth and neonatal mortality is lowest at 42+ weeks.

Report	Week of gestation	Number of births	Number of stillbirths	Stillbirth rate per 1000 births	Number of neonatal deaths	Neonatal death rate per 1000 live births
CEMACH 2004[11]	37–41	533,800	1,084	2.0	481	0.9
	42+	28,300	33	1.2	22	0.8
CEMACH 2005[12]	37	35,900	218	6.0	79	2.2
	38	87,600	238	2.7	123	1.4
	39	136,900	236	1.7	116	0.8
	40	181,900	246	1.4	123	0.7
	41	121,300	214	1.8	97	0.8
	42	23,300	26	1.1	16	0.7
	42+	4,500	3	0.7	2	0.4
CEMACH 2006[13]	37	39,533	239	6.0	76	1.9
	38	94,508	211	2.2	108	1.1
	39	151,755	236	1.6	106	0.7
	40	189,435	249	1.3	113	0.6
	41	136,637	199	1.5	79	0.6
	42+	29,342	37	1.3	15	0.5
CEMACH 2007[14]	37–41	*	*	1.9	*	0.9
	42+	*	*	1.1	*	0.7
CMACE 2008[15]	37–41	*	1,242	1.9	526	0.8
	42+	*	26	0.8	23	0.7
CMACE 2009[16]	37–41			Not reported		0.8
	42+			Not reported		0.7
MBRRACE 2013[17]	37–41	641,682	1,095	1.7	476	0.7
	42	26,504	34	1.3	16	0.6
MBRRACE 2014[18]	37–41	689,795	1,143	1.7	493	0.7
	42	33,840	54	1.6	20	0.6
MBRRACE 2015[19]	37–41	*	1,025	1.5	500	0.7
	42	*	15	0.8	7	0.4
MBRRACE 2016[20]	37–41	678,093	1,031	1.5	468	0.7
	42	18,277	19	1.0	9	0.5

*Note: the number of births were not given in the 2015 report, just the numbers of stillbirth, neonatal deaths and the calculated rates

The data for 2005 and 2006 was given by each week of gestation and these charts show clearly the declining rates for both stillbirth and neonatal death with gestation.





Comparison of rates of term and 'post-term' stillbirths

So, we have 10 years of data that consistently shows that the stillbirth and perinatal mortality rates have been lower for women birthing at 42+ weeks than for those who birthed at 37–42 weeks. The number of women concerned is huge: around 20,000 women every year take part in the natural experiment of allowing pregnancy to continue until 42 or more weeks.

This data does not include numbers of congenital abnormality, and as some of the stillbirths recorded at all gestations will have been unavoidable because of congenital abnormalities, this information would provide a clearer picture. What is also lacking is classification of stillbirth rates by mode of onset of labour (spontaneous, induction or pre-labour caesarean).

Office for National Statistics data

Another set of data, covering England and Wales, comes from the Office for National Statistics (ONS) 'Birth Characteristics' reports [ONS 2014, 2015, 2016, 2017]. Although it records the same births and deaths, this data comes from birth registrations and 'where relevant, birth registrations are linked to their corresponding NHS birth notification to enable analysis of further factors such as gestation of live births'. Therefore the figures are slightly different but show similar patterns to the findings that were reported by CEMACH, CMACE and MBRRACE. The live birth and stillbirth numbers by gestational age are available from 2014 to 2017 and the table below shows the rates for gestations of 37 week onwards. Again, it can be seen that there is no rapid rise is stillbirth rates beyond 40 weeks.

Source[21]	Gestational age at birth (weeks)	All births	Stillbirths	Stillbirth rate per 1000 births
ONS 2014	37	46,701	211	4.52
	38	93,000	221	2.38
	39	167,487	201	1.20
	40	184,930	215	1.16
	41	127,334	175	1.37
	42+	20,729	29	1.40
ONS 2015	37	50,124	194	3.87
	38	94,161	199	2.11
	39	172,011	200	1.16
	40	184,788	212	1.15
	41	121,403	123	1.01
	42+	18,415	12	0.65
ONS 2016	37	53,532	190	3.55
	38	97,157	214	2.20
	39	175,683	161	0.92
	40	181,029	225	1.24
	41	115,103	119	1.03
	42+	17,747	21	1.18
ONS 2017	37	56,003	162	2.89
	38	97,924	198	2.02
	39	175,057	146	0.83
	40	173,379	178	1.03
	41	105,743	109	1.03
	42+	15,700	15	0.96

Conclusion

Currently women are being led to believe that there is a high chance that their baby will die if they continue with their pregnancy beyond 42 weeks. However, even those studies that appear to show a protective effect of induction before 42 weeks make it clear that the risks of continuing pregnancy beyond this point are extremely low; and the evidence presented in this article does not show that women who are making the decision to continue their pregnancy beyond 42 weeks are encountering increased risk of stillbirth. It also shows that the rate of perinatal mortality is lowest at 42+ weeks.

Health care providers need to understand what this data shows and share it with women to allow them to make informed decisions about whether or not to accept induction.

We appeal to MBRRACE to reinstate the reporting by week of gestation instead of grouping the data as they have done in recent reports. We also call on the NICE Induction Guideline Development Group to consider and report on this data, and hope to see this included when the document comes out for consultation before its publication in July 2020.

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Article

Induction: First do no harm

By Katie Hickey

Katie Hickey evaluates the "Saving Babies' Lives" and "Each Baby Counts" care bundles which have led to increased numbers of inductions in the UK.

One of the most well-known medical sayings is, "First, do not harm". This phrase appears in the Hippocratic Corpus, specifically in Epidemics, book I, sect. XI: 'The physician must... have two special objects in view with regard to disease, namely, to do good or to do no harm'. [1]

In our current developed society we are extremely fortunate to have advanced medicine at our fingertips. Countless lives are now saved thanks to modern medicine, access to antibiotics, sterile surgical techniques and general improvements in nutrition. With around a quarter of all births in the UK ending in caesarean section and over a third of all labours artificially induced, one might be forgiven for thinking women in our modern society have lost the ability to give birth without medical intervention. In 1860 Oliver Wendell Holmes Senior famously remarked in a lecture to the Massachusetts Medical Society, "If the whole material medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fishes.' He observed that the injuries caused by overmedication were often masked by the disease[1.] 160 years later we are still striving to find the right balance and the appropriate use of medicine, particularly in the context of maternity services.

The proportion of births where labour was induced has increased from 20.4 per cent in 2007-08 to 32.6 per cent in 2017-18[2]. Many women and birth professionals are left asking why? How can the rates of induction be rising so sharply? How much harm are we causing to women and their babies with these high rates of intervention? Are any outcomes improved?

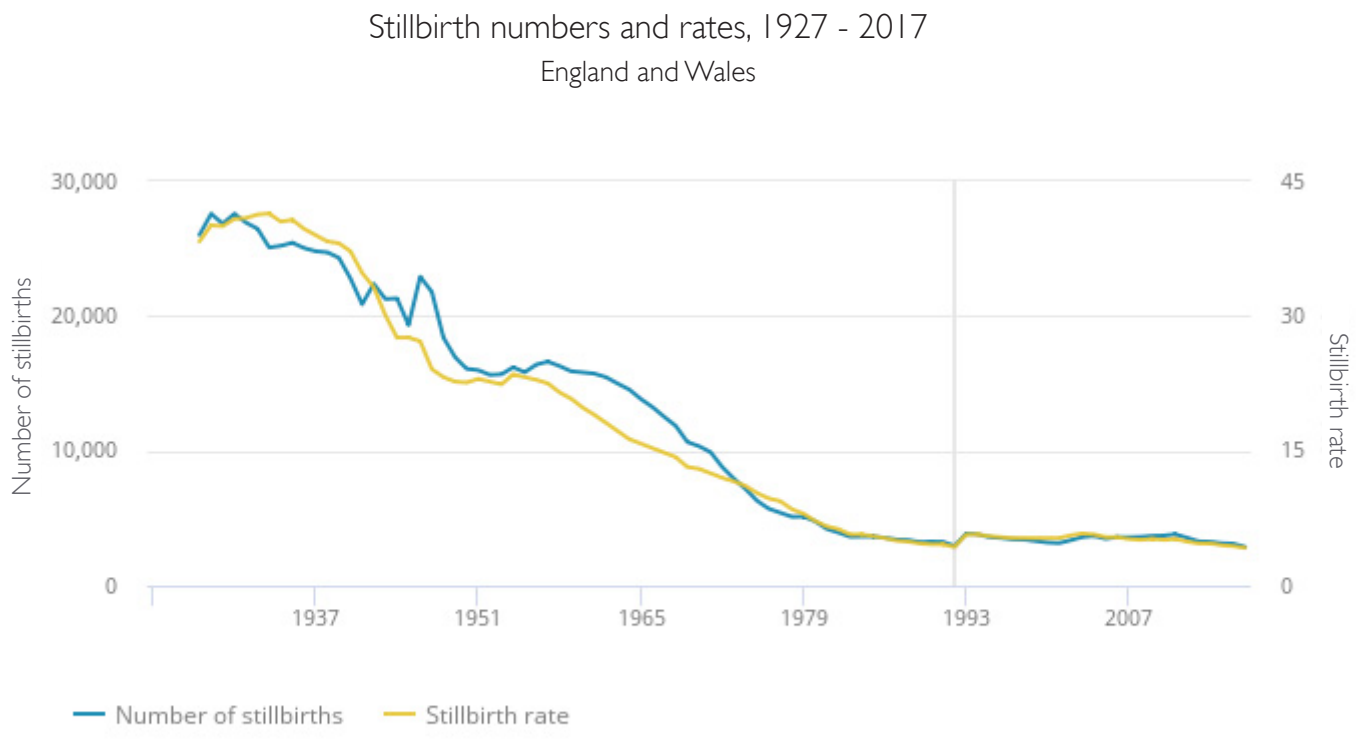
In order to understand why the rates of induction are soaring, and how this is impacting women, we need to try to understand the current climate and culture of our maternity system. This sets the scene for the rest of our conversations on the issue. It is also important to put ourselves in the position of health care providers and to understand what pressures they are under. This surely helps us to navigate the current maternity system and often helps to provide much needed context to these emotive and important conversations.

We are still striving to find the right balance and the appropriate use of medicine, particularly in the context of maternity services.

Stillbirth in the UK

Historically, the stillbirth rate in the UK has lagged behind other high- income countries; in 2015, the UK ranked 24th out of 49 high income countries and the annual rate of reduction of 1.4% is significantly lower than comparable countries (e.g. 6.8% in the Netherlands) with about a 33% variation in rates between regions.[3] In 2016, a series of articles in the Lancet called for efforts to address the disparity in stillbirth rates between, as well as within, individual countries.[4] Reducing the numbers of deaths of babies before birth remains a challenge to maternity services in high-income countries. In the UK, the majority of stillbirths occur in the antenatal period (~90%) and occur in normally-formed babies.[3]

The 2015 MBRRACE-UK enquiry found that there was a collection of failures in the care women received that contributed to the continued high rate of stillbirth in the UK. Their findings also sadly showed the same care issues being repeated since their previous enquiry 15 years earlier.[5]



Source: Office for National Statistics

There is a huge drive to reduce the national stillbirth rate in the UK, and of course this is a very welcome endeavour. In November 2015, the Secretary of State for Health announced a national ambition to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction by 2020[6]. The NHS has produced a variety of new 'care bundles' and guidelines in an attempt to address the issue. Two of these care bundles are "Saving Babies Lives" and "Each Baby Counts". I will look at both of these in more detail below.

At AIMS we are increasingly aware of the culture of fear in our maternity system and how this is used to disempower women, especially if they choose to give birth on their own terms. The fear of stillbirth is understandably one of the biggest fears of both parents and medical care givers and the new 'care bundles' discussed below have fed into the large increase in the induction rate in the UK.

What is a care bundle?

Care bundles are a small set of practices performed collectively and reliably with the intention of improving the quality of care. Some of these practices are based on evidence and some are not. Care bundles are used widely across healthcare settings with the aim of preventing and managing different health conditions.[7] A 2017 systematic review designed to determine the effects of care bundles on patient outcomes and the behaviour of healthcare workers in relation to fidelity with care bundles, showed the effect of care bundles on patient outcomes is uncertain. [7]

There is a huge drive to reduce the national stillbirth rate in the UK... The NHS has produced a variety of new 'care bundles' and guidelines in an attempt to address the issue.

What happens when evidence is lacking?

In so many elements of maternity care, evidence-based medicine is not possible due to a complete lack of high quality evidence. There are many examples of maternity policies that are actually not based on evidence and many examples of common practice that go against best evidence (continuous electronic foetal monitoring for example[8]). This leaves medical professionals searching for what they would consider to be "best practice," based on their best guess, in an attempt to bridge that gap where evidence is lacking. For women navigating the maternity system it's really important to get an understanding of these differences, especially when it is not made clear by the medical staff what is based on evidence and what is their best guess.

Saving Babies' Lives Care Bundle

The first version of the Saving Babies' Lives Care Bundle (SBLCB) was published in March 2016 and it focussed predominantly on reducing the UK stillbirth rate. In November 2017, the ambition was extended to include reducing the rate of preterm births from 8% to 6% and the date to achieve the ambition was brought forward to 2025.[6]

A second version of this care bundle was published in March 2019. It brings together five elements of care that are recognised as evidence-based and/or best practice (noting that these two are very much not the same thing as discussed above).

The 5 elements of this care bundle are:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for foetal growth restriction
3. Raising awareness of reduced foetal movement
4. Effective foetal monitoring during labour
5. Reducing preterm birth

Let's look at these elements in some more detail and pick out where evidence either supports or contradicts the proposal in the care bundle:

1. Reducing smoking in pregnancy

This is based on strong, high quality evidence. Reducing smoking in pregnancy decreases the risk of stillbirth. A meta-analysis of seven studies showed that the risk of stillbirth was 52% higher in pregnant women who smoked 10 or more cigarettes per day than those who did not smoke. It was 9% higher for those smoking one to nine cigarettes a day.[9]

NICE's Eyes on Evidence update, which provides commentary on important new evidence, said that a pooled analysis of 24 studies, which had more than eight million participants, found that the risk of stillbirth was 47% higher in women who smoked during pregnancy than in women who did not smoke while pregnant.

There is strong evidence that reducing smoking in pregnancy also impacts positively on many other smoking-related pregnancy complications, such as preterm birth, miscarriage, low birthweight and Sudden Infant Death Syndrome (SIDS). Whether or not a woman smokes during her pregnancy has a far-reaching impact on the health of the child throughout his or her life.[6]

A large proportion of women referred for smoking cessation report not attending their referral appointment. The provision and type of smoking cessation service offered to women is variable across the Trusts. In many areas smoking cessation services are not provided within maternity services and require referral to another location or care provider, these included referrals to external services, GPs and pharmacies. This need for additional referral may act as a practical barrier or a disincentive for women to attend these appointments. In addition, three Trusts did not offer referral due to withdrawal of funding for smoking cessation.[10]

This element of the SBLCB has the potential to reduce stillbirths significantly and it is supported by high quality evidence. If women cannot easily access smoking cessation services which are right for them, the opportunity for positive change is lacking.

2. Risk assessment and surveillance for foetal growth restriction

The identification of foetal growth restriction represents one of the main known clinical factors on the pathway to stillbirth.[6] The measurement of foetal growth is far from an exact science. Fundal height measurement and ultrasound, as tools for estimating foetal size, have fairly large margins of error.

The 2015 MBRRACE-UK enquiry found that the main areas of concern for stillbirth were unchanged since the previous enquiry 15 years previously. This enquiry found missed opportunities when growth of the foetus was measured but not plotted on a growth chart and the identification of babies at risk of decreased growth was missed. Sadly even in cases where these babies were identified and plotted on said growth charts no action appeared to be taken, potentially leading to the loss of those babies lives.[5]

The results show that the detection in the number of babies that are small for gestational age (SGA), defined as an estimated fetal weight below the 10th centile at last ultrasound scan, has significantly increased during the implementation of the SBLCB. This can be seen as a positive step to reducing the national stillbirth rate.

In an attempt to capture all babies that are small for gestational age it has however led to an increase in the number of unnecessary inductions of labour for many women who may not have been at risk of stillbirth. There are serious risks associated with pre-term and early term inductions that are discussed below.

3. Raising awareness of reduced foetal movement

This element of the care bundle is focussed on raising awareness amongst pregnant women of the importance of reporting reduced foetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM[6]. Findings from the 8th Report of the Confidential Enquiry into Stillbirths and Deaths in Infancy and the 2015 MBRRACE-UK Confidential Enquiry into Antepartum Stillbirth found that unrecognised or inappropriately managed episodes of RFM are contributory factors to avoidable stillbirths.

The AFFIRM study found that a care bundle which recommended all women have an ultrasound assessment of foetal wellbeing following presentation with RFM after 26 weeks' gestation, and offered induction of labour for recurrent episodes of RFM after 37 weeks' gestation did not significantly reduce stillbirths.

We do not fully understand how a decrease in movements is linked to stillbirth and even when we increase awareness and intervention the results show a disappointing impact to the rate of stillbirth.

The evaluation into implementation of the SBLCB10 showed 49% of women said they were concerned that their baby's movements had slowed or stopped in their current pregnancy when explicitly asked. A high proportion of women perceiving RFM attended their maternity unit (77.3%). of those women attending their maternity unit with RFM, 74% received foetal heart monitoring, 65% of women received an ultrasound scan; 20% at every visit. Half were scanned within 24 hours and 20% of women were scanned within 2 to 3 days. 55% percent of women reporting RFM had induction of labour. You can see how this element of the care bundle has contributed significantly to the increases in the national induction rate.

One of the key interventions in elements 2 and 3 of the SBLCB, discussed above, is offering early birth for women at perceived risk of stillbirth. The Avoiding Term Admissions Into Neonatal units (Atain) programme has identified that babies born at 37 – 38 weeks gestation were twice as likely to be admitted to a neonatal unit than babies born at later gestations. There are also concerns about long term outcomes following early term birth (defined as 37 and 38 weeks). These concerns relate to potential long term adverse effects on the baby due to birth prior to reaching maturity, for example, the baby's brain continues to develop in-utero at term. One example is the risk that the child will subsequently have a special educational needs (SEN). The risk of this outcome is about 50% among infants born at 24 weeks of gestational age and it progressively falls with increasing gestational age at birth, only to bottom out at around 40 – 41 weeks[6].

Health care providers must be cautious about recommending induction of labour for perceived reduction of foetal movements in the absence of evidence of compromise to the baby. That being said poorly managed episodes of RFM have been highlighted in previous enquiries into stillbirth as missed opportunities to reduce the stillbirth rate. There is no easy answer as yet.

4. Effective foetal monitoring during labour

In 2017 a Cochrane review asked the question: "*Is continuous cardiotocography (CTG) to electronically monitor babies' heartbeats and wellbeing during labour better at identifying problems than listening intermittently?"* The findings were that CTG during labour is associated with reduced rates of neonatal seizures, but no clear differences in cerebral palsy, infant mortality or other standard measures of neonatal wellbeing. However, continuous CTG was associated with an increase in caesarean sections and instrumental vaginal births compared to intermittent monitoring.

The use of foetal heart rate monitoring of any kind is not based on evidence. We do not know if monitoring foetal heart rates, even intermittently, improves outcomes for mothers and babies. It is based on an assumption that it will improve outcomes but it is that same assumption that leads to continuous CTG being used more and more widely. Very interestingly, new NICE guidelines on caring for women having a vaginal birth after a previous caesarean (VBAC) now clearly state that there is no evidence to support routine use of continuous CTG for these births, despite it being defined as a "high risk" birth in the eyes of the medical care givers [11].

Continuous CTG monitoring is still used as standard on labour wards across the country without evidence that it improves outcomes, and with evidence that it causes harm. We do know it can massively impact a woman's ability to cope with labour as it restricts mobility and often leads to further interventions such as epidural and caesarean birth.

The INFANT Trial was set up to find out whether computer software (produced by INFANT K2 Medical Systems) which provided interpretation of continuous electronic foetal monitoring (EFM) to support decisions about care in labour for women having continuous EFM could reduce birth injury and stillbirth compared with continuous EFM used on its own. You can read AIMS' summary of the research here: https://www.aims.org.uk/journal/item/infant-trial

The INFANT Trial team's conclusion was that *'…use of computerised interpretation of cardiotocographs in women who have continuous electronic foetal monitoring in labour does not improve clinical outcomes for mothers or babies.'*

The use of foetal heart rate monitoring of any kind is not based on evidence. ... We do not know if monitoring foetal heart rates, even intermittently, improves outcomes for mothers and babies.

5. Reducing preterm birth

Preterm birth (PTB), defined as birth at less than 37+0 week's gestation, is a common complication of pregnancy, comprising around 8% of births in England and Wales[12]. Babies born preterm have high rates of early, late, and post-neonatal mortality and morbidity.

We know from MBRRACE-UK surveillance data that 70% of all stillbirths and neonatal deaths occur in babies born before term and nearly 40% are extremely preterm, being born before 28 weeks' gestation.

This element of the care bundle is new and is seen as an addition to the second version of the SBCLB. It aims to better predict those babies who are at risk of preterm birth and treat, where possible, to try and prevent preterm birth. For those babies where preterm birth is unavoidable then appropriate care in specialist facilities should be arranged (many babies are currently born in facilities that are unable to cope with their medical needs appropriately). Analysis of data from the National Neonatal Research Database has shown that extremely preterm birth outside an obstetric unit co-located with a tertiary neonatal intensive care unit (NICU) is associated with a 50% increase in neonatal death or severe brain injury, yet in 2016 approximately 1 in 3 extremely preterm births were in a hospital without a NICU[6].

It has been acknowledged that the NHS will not achieve the national Maternity Safety Ambition to halve the rates of stillbirths, neonatal and brain injuries that occur during or soon after birth by 2030, unless the rate of preterm births is reduced. The Government then set an additional ambition to reduce the national rate of preterm births from 8% to 6%. It is hoped that this new element of the SBLCB will contribute to the reduction of preterm birth.[6]

What has been shown so far

The UK stillbirth rate decreased to 4.2 per 1,000 total births in 2017, the lowest rate on record with figures available back to 1927; in the last decade since 2007 the stillbirth rate has decreased by 19.2% (ONS). In July 2018 a published evaluation of the implementation of the Saving Babies' Lives Care Bundle in early adopter NHS Trusts in England10 showed the following results:

- In participating Trusts, stillbirth rates have declined by 20% over the period during which the Saving Babies' Lives Care Bundle (SBLCB) was implemented, although this improvement cannot be unambiguously attributed to the Care Bundle. The crude stillbirth rate was 4.14/1,000 births before SBLCB and 3.31/1,000 births after SBLCB. Term singleton stillbirths declined by 22% over the same period. There was no demonstrable relationship between stillbirth rates and the overall implementation score for the SBLCB.
- Significant variation in the stillbirth rate persists across the early adopter Trusts beyond that explicable by care level and aggregated deprivation score. This suggests that there may be variation in practice between Trusts and therefore scope for improvement in some. Associations with deprivation suggest a need for wider scale social and public health policy changes to tackle inequality in addition to the SBLCB if the stillbirth rate is to be further reduced.
- It was not possible to determine whether implementation of SBLCB or any of its individual components per se reduces stillbirth or affects any of the associated clinical and service outcomes. However, due to the nature of the interventions it is highly plausible that SBLCB contributed to the continued improvement in stillbirth rate in the early adopter Trusts.

There has been a large impact to maternity services and a knock-on effect to women and their babies:

- Following implementation of the SBLCB in study sites, the number of ultrasound scans performed increased (by 25.7%) as did interventions at or around the time of birth including induction of labour (by 19.4%) and emergency caesarean section (by 9.5%). The number of elective caesarean sections also increased over the timeframe of this analysis (by 19.5%)
- Rates of preterm birth, admission to a neonatal unit and the number of babies receiving therapeutic cooling have increased in study sites during the timeframe of the SBLCB evaluation; by 6.5%, 17.1% and 27.7% respectively.
- Awareness of the SBLCB by staff was modest, with 42% of staff claiming to be unaware of it although staff were implementing all or part of the bundle as part of their daily practice. Awareness was lowest among frontline staff and highest in managers.
- The methodological quality of clinical practice guidelines in relation to the SBLCB were generally of low quality and highly variable between Trusts.

Version 2 of SBLCB includes some excellent improvements on the first version. There is acknowledgment that during implementation of some of the elements of the care bundle there was an increase in interventions to women not really at risk. *"It is recognised that the previous bundle imposed significant burdens on service providers. In particular, increased numbers of ultrasound scans and increased rates of induction of labour and emergency caesarean sections were observed. By being more specific this bundle (version 2) will help focus intervention more in pregnancies genuinely at risk of complication.....there are opportunities to reduce obstetric intervention."*

This second version really urges care providers to think more carefully and to avoid intervention unless there is clear evidence of compromise to the baby. It also reminds them to "be vigilant to include women in the decision-making process" which is a very unfortunate turn of phrase as it implies that women are only to be "included" in the decision making - whereas in fact the decisions about what to accept or decline can only be made by the woman. This was something that was distinctly lacking in the first version of this care bundle and the changes are very welcomed. SBLCB version 2.... "*highlights the important principles of good communication, choice and personalisation which help empower women to be involved in decision making about their care. A good way to apply these principles is through the implementation of continuity of carer..."* What a relief to see this point acknowledged, but we shall wait to see how this trickles down to front line staff who need to understand the importance of these aspects of the care they provide. It's sad that these elements were missing from the first version of the bundle.

Each Baby Counts

Each Baby Counts has the aim to halve the UK's national rate of stillbirth, maternal and neonatal deaths and brain injuries that occur during, or soon after birth, by 2025. It is aiming to do this by investigating every stillbirth case reported to them and identifying avoidable factors in every case. The programme also recognises the impact that each of these tragic events has on parents and families. The aim is to ensure that maternity services learn from mistakes to reduce and prevent avoidable harm wherever possible.

The 2018 progress report for Each Baby Counts[13] makes for a sad read. The number of incidents where different care might have led to a different outcome still remains high. 71% of the babies might have had a different outcome with different care.

The report suggests that the reasons for stillbirth, early neonatal death and brain injuries are complex and multifactorial. For the babies reported to Each Baby Counts, the reviewers concluded that there was rarely one single cause of the stillbirth, early neonatal death or brain injury. Rather, on average, there were 7 critical contributory factors leading to these devastating outcomes. This complexity and interdependency highlights the need for continued investment to improve care for women and babies across the UK. We are aware that this is not a case-controlled trial but an audit, so the results and conclusions need to be interpreted with caution – we don't know how many of the babies who were fine would also have experienced some of these contributory factors.

Lack of consistent care

AIMS often hears from women who seem to be hounded incessantly, bordering on harassment by their health care providers. Some are coerced at every opportunity to agree to a particular intervention for, they say, the safety of their baby's life when there is very often no evidence that a specific baby is at risk (see the AIMS article "beware the dead baby card[14]"). And yet, clearly other women are still falling through the gaps and are not being given the care and attention they need. With the current reports indicating nearly three quarters of babies who've died or been seriously injured during birth could have different outcomes with different care, this lack of attention to women is extremely worrying.

The maternity services are increasingly over-stretched. Low staffing levels, staff burn out, lack of training and support are key elements that prevent women receiving high quality care. A 2018 paper in the British Journal of Midwifery focussed on how women get information and make decisions regarding induction of labour and they found midwives presented induction as the preferred option, and alternative care plans, or the relative risks of induction versus continued pregnancy, were rarely discussed. Women reported that midwives often appeared rushed, with little time for discussion[15.] With 42% of health care providers claiming no knowledge of the SBLCB[10] one might question what is the point of the NHS spending £94M per year[10] on implementing the care bundle?

We are left wondering how much influence the service users consulted on during the formation of these care bundles really has? Why has it taken until the second version of the SBLCB to place any attention on the way we deliver maternity services and the emphasis on women making decisions about their own bodies, babies and births? After all, it is women, and their babies, who are subjected to the consequences of practices, policies and guidelines.

Continuity of Carer

As well as focussing on medical intervention and technology we welcome the included focus on Continuity of Carer. When a woman is cared for by the same midwife throughout her pregnancy, birth and postnatal period outcomes improve dramatically. The relationship a woman forms with her midwife can literally make the difference between life and death.

The second version of SBLCB[6] does highlight evidence that continuity models improve safety and outcomes. Women who receive Continuity of Carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience preterm birth. It says, this model of care will also be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.[6]

Whilst this is a very welcomed addition to the care bundle we have to question why this isn't a stand-alone element of the care bundle. Given that the evidence of benefit of Continuity of Carer is not new it is increasingly frustrating to not see this focussed on more specifically. It seems as though rolling out Continuity of Carer falls below the priority of using technology, machines and obstetric intervention time and time again and that is extremely disappointing.

The Albany Midwifery Practice is a shining example of how Continuity of Carer can provide outstanding outcomes for women[16]. The Albany Practice mostly cared for women from BAME origin in an area of high social deprivation in South East London. Despite these women being at higher risk for poor outcomes and increased intervention the results show the opposite. https://www.aims.org.uk/journal/item/the-albany-analysis . How many times do these lessons need to be relearnt before we see a significant change in the way maternity services are offered to women? Despite version 2 of the SBLCB highlighting how Continuity of Carer should be offered to women particularly from BAME backgrounds[6], it remains to be seen if this is followed through.

When we have clear, unequivocal evidence that continuity of carer improves outcomes for women and babies[16] why is the NHS not focussing more of its efforts on that? AIMS would like to see relationships (based on evidence of improving outcomes) replacing technology (not based on evidence of improving outcomes) wherever possible.

Conclusions

When we question why the rate of induction is rocketing in the UK it helps to have some understanding of the climate and culture of the maternity system today. "Your baby is better out than in" seems to be a common thought amongst health care providers and given the care bundles and guidelines which are in place it is hardly surprising that they feel this way.

We cannot turn a blind eye to the fact that induction of labour itself is not a benign procedure and has its own associated risks, some of which are the exact risks we are trying to avoid, hypoxic injury to newborns being one[17]. The 2018 report on the SBLCB showed rates of preterm birth, admission to a neonatal unit and the number of babies receiving therapeutic cooling have increased by 6.5%, 17.1% and 27.7% respectively (comparing rates before and after the implementation of the SBLCB). We cannot say at this time what effect these increasing interventions are going to be causing in the long term. However, with respect to mental and physical health of mothers and children, a 27.7% increase in therapeutic cooling (which is carried out for babies that have suffered hypoxic injury during birth) shows that many babies are indeed being damaged by the increase in induction of labour.

In an attempt to capture all babies at risk it has led to an increase in pre-term and early term inductions and caesarean sections. How can we look at this in terms of balancing harm vs good? The dilemma is that early term birth may reduce the risk of an uncommon but serious adverse event (stillbirth or neonatal death) while at the same time increases the risk of much more common adverse events which can also have devastating outcomes. Decision-making balances the risks of causing one form of harm to relatively large numbers of mothers and infants in order to prevent another form of harm to a relatively small number. For example, at 37 weeks, 10 inductions will lead to one additional baby being admitted for neonatal care but it will require more than 700 inductions to prevent each perinatal death.[6]

Does increasing the rate of induction of labour reduce the incidence of stillbirth? There is conflicting evidence and opinion. As there are so many changes happening in our maternity system at one time it is difficult to prove that one element out of many is the reason for a decrease in our national stillbirth rate. In an area so highly complex and emotive, coupled with uncertainty and the lack of unequivocal, unbiased scientific evidence, it is understandable that the rates of intervention have rocketed.

In the course of writing this article I have battled myself with how I feel about all of these elements and I am also eight months pregnant at the time of writing this piece. The death of a baby has lifelong consequences for the family who have suffered this tragedy. Induction of labour is not the only answer to reducing the stillbirth rate and, as we have discussed, it is not without its own risks that sometimes result in devastating outcomes.

Women MUST be at the centre of their care and decision making. Striking the balance between the use and overuse of medicine is not always easy, especially when the potential consequences either way are totally devastating. Only when women are given the time, respect and support that they deserve can we really see this balance being reached. Whilst women are not enabled to make truly informed decisions about their care, the offer of induction will continue to be problematic.

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Article

Informed Decision Making - does research help us?

By Ann Roberts

Ann Roberts uses the BMJ's satirical "parachute" study to explain the flaws in the 35/39 Induction Trial

Each Christmas, the British Medical Journal offers us a satirical, and often very funny, mock up research study. These are always beautifully written, so that at first glance one almost believes them to be real. This Christmas the study was entitled: "Parachute use to prevent death and major trauma when jumping from aircraft: randomized controlled trial"[1].

As I read it the similarity between this imaginary trial and the 35:39 Induction trial of 2016 was strikingly obvious: "Randomized Trial of Labour Induction in Women 35 Years of Age or Older"[2].

So for those interested in RCTs (randomised controlled trials) and/or induction, but who have neither the time nor patience to read through the detail of either of the above, I have written a short comparison. References to the full trial texts and results are at the end of this article.

The parachute trial, as I will call it, purported to look into the risk of death or major trauma when jumping from an aircraft from a height, either with or without a parachute. Lots of people were invited onto the trial but the majority declined – the risks seemed too high. So the study design had to be altered and the aeroplanes would now be on the ground. Participants joined up to this and were randomised ie put into different groups; with or without parachutes.

The induction trial, as I will call it, was designed to look at how inducing women aged 35 and older at 39 weeks would affect adverse outcomes including Caesarean Birth (CB) rates. Thousands of women were invited to take part over a three year period, but just under 90% declined – the recruitment period had to be extended, and the number of hospitals involved increased to get enough participants to make the trial valid, ending up with 619. They were randomised to induction at 39 weeks or so called Expectant Management (waiting for labour to start spontaneously).

Our local hospital, the Norfolk & Norwich University Hospital (NNUH), invited 143 eligible women, just 10 agreed to enter the trial.

The main outcome of the parachute trial was that there were no deaths or serious injuries whether the participants jumped with or without a parachute - which is a great result. The Caesarean Birth (CB) rate was also similar in both groups; this was considered proof that induction does not increase the CB rate. There were no stillbirths in the induction trial, which is a great result.

Conclusions

Parachute use did not reduce death or major traumatic injury when jumping from aircraft in the first randomized evaluation of this intervention. However, the trial was only able to enrol participants on small stationary aircraft on the ground, suggesting cautious extrapolation to high altitude jumps. When beliefs regarding the effectiveness of an intervention exist in the community, randomized trials might selectively enrol individuals with a lower perceived likelihood of benefit, thus diminishing the applicability of the results to clinical practice.

There were also no deaths or serious morbidities in the induction trial, whether the women were induced or not, which is a great result - although by then this was not the primary focus of the trial. The Caesarean Birth (CB) rate was also similar in both groups and this was considered proof that induction does not increase the CB rate.

Conclusions

Among women of advanced maternal age, induction of labour at 39 weeks of gestation, as compared with expectant management, had no significant effect on the rate of caesarean section and no adverse short-term effects on maternal or neonatal outcomes.

DISCUSSION

In the induction trial it is a reasonable assumption that the women who agreed to take part were happy to be induced at 39 weeks – perhaps even hoped to be. They may therefore be viewed as a self-selecting group of women who embraced the concept of early induction. Women who did not wish to risk being randomly assigned to early induction declined to enter the trial, just as some people decided not to risk jumping out of an aircraft at altitude without a parachute!

The women were 35 years and older, and they were "primips" i.e. first time mothers, these are both groups who are often told they may have higher rates of intervention and assistance in giving birth. Even so, a CB rate of 32% (induced group) and 33% (waiting group) is high for a group of low risk women. Even higher is the 38% (induced group) and 33% (waiting group) whose babies were assisted out with forceps or ventouse. Only 30% of women in the induction group and only 34% in the expectant management group had a vaginal birth without assistance.

So what happened? Why were these rates of interventions so high?

Looking deeper into the results reveals something that is interesting. As is normal in a RCT, the "intent to treat" principle means that women stay in their groups for the results and analysis, even if they did not conform to the protocol of their group; women cannot be forced into or denied treatment. As a result quite substantial percentages of women in both groups crossed over from one group to another. For example, some women in the induction group went into labour naturally before 39 weeks or declined induction. A surprising number of women in the expectant management group were induced, both for medical and non-medical reasons (e.g. maternal request).

All the women were cared for in consultant led units; we do not know whether the expectant management group were encouraged to labour in a way that maximises straightforward vaginal birth. Epidural use was high in both groups, we know this increases assisted birth rates. Monitoring is not recorded; however, it is likely that most of the women in both groups would have been continuously monitored. We know from numerous studies over the last 40 years that continuous monitoring increases the caesarean birth rate.[3]

So, just like the parachute RCT – the induction trial took two groups of similar people, who were willing to accept the intervention; treated them in a very similar manner and declared the similarity in outcomes to be proof of something that it really is not.

Epidural use was high in both groups, we know this increases assisted birth rates. We know from numerous studies over the last 40 years that continuous monitoring increases the caesarean birth rate.[3]

QUESTIONS

What happened to the women who clearly preferred not to be induced and therefore declined to enter the trial – all 5836 of them? Did they go on to labour spontaneously, did some labour at home or in a MLBU, what were their outcomes? We know that if they avoided induction their likelihood of having a straightforward vaginal birth is considerably higher.[4] We don't know what happened to those women because that's how RCTs work; the more interesting and useful information is not recorded. It would have told us so much more if these women had been followed up.

The media reported the induction trial as if it was a triumph and many in the medical profession seized upon the "no increase in CB following induction" as a go ahead to allow induction rates to rocket, and to recommend early induction to women over 35. Many midwives and people who work in the field of birth education have spent many long hours writing their thoughts on this trial – and now I have joined them.[5]

As an antenatal educator with about 12 hours to spend on pregnancy, labour, birth, feeding, baby care and parenting, becoming a family and more, we really haven't time to spend the hours it would take to unpick and challenge RCTs like this one. Luckily, there is some good reading out there, backed by the research that does make sense; I attach some references below. Happy reading and informed decision making – and Good luck!

References:

1 - The Parachute Trial: BMJ 2018; 363 doi: https://doi.org/10.1136/bmj.k5094 (Published 13 December 2018) Cite this as: BMJ 2018;363:k5094

2 - The Induction Trial with results: N Engl J Med. 2016 Mar 3;37 4(9):813-22. doi: 10.1056/NEJMoa1509117 www.ncbi.nlm.nih.gov/pubmed/26962902 Full text with all the results here: www.nejm.org/doi/10.1056/NEJMoa1509117?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dwww.ncbi.nlm.nih.gov

3- Continuous Foetal Monitoring in low risk women www.ncbi.nlm.nih.gov/pmc/articles/PMC4010242/ AIMS' information on monitoring in labour: www.aims.org.uk/information/item/monitoring-your-babys-heartbeat-in-labour

4- We know that waiting for labour to start spontaneously and labouring in a low risk environment in the care of midwives can result in lower rates of CB and assisted birth, even for older first time mothers: www.npeu.ox.ac.uk/birthplace/birthplace-follow-on-study

5 - AIMS' Research Review by Gemma McKenzie on the 35/39 trial: www.aims.org.uk/journal/item/induction-and-age

Way back in 2002 midwife Tricia Anderson wrote this article which still resonates today, it is written about midwifery care and home birth but has so much relevance to how we treat women and induction trials in particular: https://www.pregnancy.com.au/out-of-the-laboratory-back-to-the-darkened-room/

Article

Waterbirth and Induction of Labour

Dianne Garland, Waterbirth Midwife and Emma Ashworth, AIMS Journal Editor break down the barriers to accessing water when a woman decides to be induced.

Dianne Garland

The proportion of births where labour was induced has increased from 20.4 per cent in 2007-08 to 32.6 per cent in 2017-18[1]. The rationale for induction is varied, and the methods used can impact on the option of using water for labour and or birth. However, just because a woman is accepting the offer of induction does not mean that she is automatically then not able to use water for pain relief. Provided that there are no other medical reasons why water may not be suitable for labour andor birth, induced labour should not mean that women are denied access to this powerful labour support and form of pain relief, and indeed some trusts are supporting this already in their guidelines.

The first stage of induction is normally attempting to start labour with a membrane sweep, or 'stretch and sweep', which is when your midwife inserts a finger into the opening of your cervix and moves their finger around in the hope of

stimulating labour. If labour starts after a stretch and sweep women are usually supported to access a birth pool.

If a stretch and sweep doesn't lead to labour starting, the next stage is usually a prostaglandin induction (hormone pessary or gel). If your waters have already ruptured the pessary may not always be required as the cycle of labour hormones may already have commenced, or have been triggered by the change in pressure of your uterus.

The aim of the pessary or gel is to open the cervix in order to allow your midwife to rupture the membranes (breaking the bag of water that surrounds the baby), which triggers changes both in pressure within the uterus and chemical hormonal receptors to hopefully start or progress labour.

Current NICE guidelines for monitoring the fetal heartrate during induced labour states that continuous fetal monitoring should be used where there is a risk of overstimulation of the muscles of the uterus (hyperstimulation). Prostaglandins and synthetic oxytocin (syntocinon – the drug used in the drip, as explained below) both carry these risks.

Once the fetal heart rate is confirmed as normal, intermittent auscultation should be then offered, unless intravenous oxytocin is used. Women are often able to go home after having a prostaglandin gel or pessary, unless there is an adverse reaction to the hormones.

If women go on to established labour with prostaglandin induction alone they should be treated like other labouring women and have access to birth pools, as intermittent auscultation is normal practice whilst using a birth pool. Some NHS trusts may not have adopted NICE guidelines so it is important to discuss this with them in advance.

If continuous monitoring is still recommended and you accept it [note: AIMS' information sheet on monitoring in labour may help you with this decision[2]] or if you want this type of monitoring, this does not stop you from being able to access a birth pool. Many hospitals have a wireless (telemetry) system for continuous monitoring in water. Traditional electronic monitoring, which is often used with induction, cannot be used underwater. The monitor needs to be water sealed to prevent injury to you or damage to the equipment and the telemetry systems are designed for this purpose.

Another option which is very valuable to many women is to use a shower, which can be directed to any aspect of your body which is sensing the contractions. Do not underestimate the power of just the sound of running water and a relaxing shower in helping to boost your labour hormones.

Finally, labour maybe enhanced and occasionally started with an intravenous synthetic oxytocin hormone, syntocinon, which is given in a drip in your hand which will remain attached until after you birth. Having an IV cannula in water is possible but may raise concerns about infection in your hand. Women can easily keep their hand out of the water or ask for the cannula to be covered by a comfy fitting plastic glove and sealed with tape at your wrist. It is most likely that your health care provider will also strongly recommend that you are continuously monitored when using the drip because of the risk of overstimulation of the muscles of the uterus. If your hospital has a telemetry system this should still be possible in water.

The IV line that delivers the syntocinon drip is connected to a machine which does need to be kept away from water and condensation, although some manufacturers supply protective covers. To ensure that this is possible, extension kits are available so that the pump itself can be well away from the pool. Although battery powered IV pumps are available, there is still no possibility of electrocution with a mains unit as the only connection between the woman and the machine is via plastic piping. There is therefore no difference in risk of electrical injury compared to using the machine when the woman is out of water provided the pump itself is kept away from the pool and wet areas which can be achieved by an extension kit. Furthermore, any theoretical risk of electrocution can be almost completely removed with the use of an RCD[3] unit. Finally, as an absolute fail-safe, ensuring that the electrical lead is too short to reach the pool itself would mean that no one could bring the pump close enough to the pool to allow it to fall in!

Some pumps are available as battery powered units, which might be an acceptable option for Trusts who would prefer

not to use mains-connected pumps, and the same extension units can be used with these to keep the pump unit itself away from any water.

It is important to keep in mind the limitations that come with using machines to monitor women and their babies during labour. Continuous fetal monitoring machines, whether the traditional machine with wires or the newer wireless version (telemetry), come with limitations. Monitor heart rate transducers can sometimes find it difficult to maintain contact due to several factors (movement of mother or baby or BMI of mother). In these situations it would be recommended to ensure there is no baby compromise and mother may be asked to leave the water until this can be established.

Cardio toco graph monitors (CTGs) are sensitive pieces equipment and despite professional and hospital responsibility ensuring they remain fit for purpose, sometimes they do not work correctly. This may mean that particularly telemetry (wireless) devices, may not be available in all situations whilst they are being repaired.

All forms of pain relief have pros and cons, as health professionals we are able to provide information (classes, leaflets and discussion). Support groups and charities are available with similar opportunities to have evidence based information given for a mother to make informed decisions for labour and birth.

Dianne Garland , SRN RM ADM PGCEA MSc
Owner of www.midwifeexpert.com and author of "Revisiting Waterbirth- an attitude to care"

References

1 - NHS Maternity Statistics 17-18 https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2017-18

2 - www.aims.org.uk/information/item/monitoring-your-babys-heartbeat-in-labour

3 - www.electricalsafetyfirst.org.uk/guidance/safety-around-the-home/rcds-explained/

Events in June 2019

Leigh Day Women's Rights in Healthcare Seminar
When: 6th June 2019
The law firm's second seminar on women's rights in healthcare. Topics include law on consent and perineal tears, menopause, IVF, BAME women's health... *Read more*

Women's Rights in Healthcare 2019
When: 6th June 2019
Speakers will discuss topics including: Post partum psychosis Maternal birth injury Menopause Transgender rights The health and wellbeing of ethnic mi… *More information here*

MBRRACE-UK/PMRT and National Child Mortality Database (NCMD) Stakeholder Meeting
When: 12th June 2019
Venue London
Please email jenny.kurinczuk@npeu.ox.ac.uk for details.

ARM Summer Study Day
When: 15th June 2019
ARM Summer Study Day and National Meeting - Midwifery Near and Far The African Maternity Link Essex One to One Midwives The Osborne Kneeling Chair in… *Read more...*

International Normal Labour and Birth Research Conference
When: 17th June 2019
Normal Labour and Birth: 14th Research Conference Monday 17th – Wednesday 19th June 2019, Grange Over Sands AIMS volunteer Jo Dagustun will be speaking… *Read more...*

See all events at www.aims.org.uk/events/page/1

Article

In Search of Justice

By Beth Whitehead

Beth Whitehead was assaulted during her birth. She went to the police to report the assault and this is the story of her experience.

Ever since my daughter was born, I had this inner knowing that things happened at her birth that were not right. I was aware that I had rights and choices but not only were they not respected but my birth preferences were deliberately dismissed in favour of hospital protocols that didn't make much sense to me. I tried my best to move on but just could not stay on top of the feeling of injustice. I felt I had to do something about it but was not sure what or where to start.

I felt rattled by the sight of authority since the birth. I used to feel safe in their presence. I thought it was bizarre but it probably makes sense as I was harmed in the hands of medical authority. Something in my subconscious was reminding me that authority is dangerous, be careful. My subconscious didn't quite understand that my surroundings have changed. I felt I could not sit with this fear and sense of injustice any longer or let it run my life. I was told I have rights. People who had their wallets stolen can report it to the police. Why not me, when my dignity and human rights were robbed? They are more important than a credit card and a few pounds. I decided that I would go and report my birth abuse to the police.

At the time I had already written up what happened and checked it against my maternity notes. Luckily, I had a doula at the birth who continued to support me so I talked with her about what I remembered just to make sure it was not my imagination. Traumatic memory is so vivid, visually and in texture that it was replaying in my mind and body for months. She confirmed that it was exactly what happened. I felt relieved because I had doubts in my head for a while that maybe it was me being negative and desperately hoping that things hadn't happened the way that they did because acknowledging what happened means I felt I needed to do something about it. What I experienced was violence, I was a victim. I didn't want to be a victim but I had no choice. It was what happened to me.

I told my doula I wanted to report it to the police because I felt how the midwives treated me was criminal and didn't want what happened to me to happen to other women. I asked her if she would accompany me. She said yes without hesitation. It really helped me to feel supported and not alone. We decided on a day and time. I tried not to think about it and to not expect anything. I didn't know what to expect anyway.

It had been over a year since the birth. I was still not able to talk about my birth without breaking down in tears. I brought along a detailed written statement just in case. We arrived at our local police station in the evening. It was quiet and the air was crisp. As we walked in, we were told to take a seat. My doula asked me how I was feeling. I felt relaxed as I was just going to tell them what happened.

Five minutes later, I was called up. The duty officer asked me to tell her briefly what I wanted to report, when and who were involved. Suddenly, I felt overwhelmed, I didn't know where to start, whether to tell her how I was coerced into a vaginal exam, how my gas and air was taken away and my request for it back was repeatedly declined and how it made me feel like a dying animal on the roadside, how I was restrained, ended up with a horrendous vaginal tear or how I was given synthetic oxytocin without being told and against my birth plan. "Briefly", how?! I tried my best to describe the assaults in a few sentences before tears began rolling down my face. I requested that if possible I would like to speak to a female officer because of the sensitive nature of the incident. She said she would try to but they didn't work like that. I could either talk to whoever was on duty or make an appointment to come back again. I said that was fine as I would like to make the report that night.

Ten minutes passed that felt like eternity. We were invited by a police officer to go through the security doors into a small interview room with a recording device. He asked me to explain what happened. I got out my written statement. He said kindly that if it was easier that he could just read through what I had written. I handed over my papers. He patiently read through every sentence I wrote from the beginning to the end.

He looked up and said that unfortunately it was a medical matter so it was not something the police would investigate. I didn't quite understand because it was an assault that happened in medical setting but still an assault.

He said because as police officers, they were not trained in the medical aspects, they could not investigate the matter. Because the birth was over a year ago there was nothing he could do. Then it dawned on me that when a birth is medicalised it takes place within an institution and is transformed into a medical matter that the police feel means that law enforcement doesn't apply. Nor was it taken seriously. It didn't feel right.

I was not happy with the response and wanted to understand more, so I asked under what circumstances would the police investigate. He said because it would be considered common assault at best, it has to be reported within 6 months of the incident for them to take action. What?! How is coercion into vaginal exam, someone penetrating my vagina with their hands, only considered a common assault? Why was it not a sexual assault as it involved violation of my private parts and still affects my sexual relations? Then came the raw realisation that the law does not recognise women birthing as being in a sexual state nor the violation of our private parts as having sexual health implications. The law does not understand birth. I felt angry, not understood and not protected.

However, it was not the police officer's fault. He was apologetic about being unable to take any further action and he suggested that I could make a complaint to the hospital or to the CQC (Care Quality Commission) or PHSO (Parliamentary Health Services Ombudsman). I said that I felt there was no point complaining to the hospital as their staff were the ones that carried out the assault. It was unlikely they would own up to it. Why would you ask offenders to investigate their own wrong doing?! It would just be a call to cover their own tracks. It was clear that it was not something the police want to get involved in. This conversation would not achieve anything. We asked for the name of the officer and the police reference number and left.

Did I feel let down by the law and the police? Yes, absolutely! I felt better for having told them my story and learned the truth, the reality of how women are not really protected when accessing medical facilities when giving birth. I think it extends to outside maternity services too. It was a difficult lesson. The anxiety that women feel after experiencing birth abuses is justified. A medical system that does not listen to or respect women and their bodies is not safety. We feel anxious when we do not feel safe.

So, why should women consider reporting their birth assault to the police? It's like the #metoo movement. If lots of us make our experience heard, it cannot be ignored. It took a long time for domestic violence to be recognised as a criminal offence. It will take yet more effort to have obstetric violence be recognised legally. If every woman takes a secret recording device into the birth room it will not take long for people to see that when women are not listened to and their body autonomy is not respected, what is done to them is violence. Violence in the birth room is so normalised, just watch One Born Every Minute. It will take lots of women speaking out, making complaints to change the culture.

If we all turn up to our local police station to report the abuses we experienced accessing health services during pregnancy and while giving birth there will be a long queue of us. It's a way to recognise the violence and the reality of how women are not being listened to and respected by many maternity services staff and in the health system. It's very much the culture and practices that need to be addressed by the NHS to prevent substandard care and violence. The answer is respectful care, Continuity of Carer and a culture of respect and openness towards women and patients. It is within the institution's resources and power to support women properly through one of their life's most important transitions. No more excuses.

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What next?

1. Write down everything you remembered, timings and presence of people. Ask your birth partner(s) to do the same.
2. Obtain copy of your maternity notes (free under GDPR data protection regulation) from the hospital you birthed at to check the details.
3. Bring along written statements and maternity notes when you feel ready to report to the police. It may be a good idea to make an appointment.
4. Always go with someone that can support you and keep an open mind.
5. Get a police report reference number and the name of the officer.
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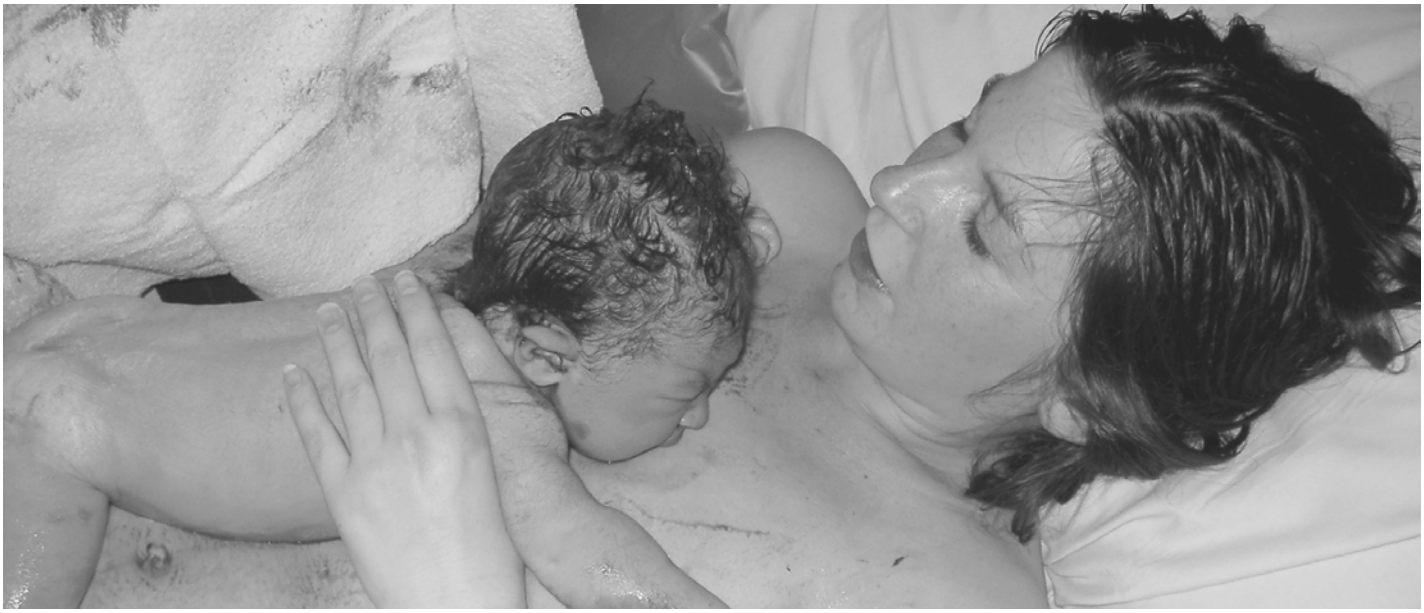
Article

My favourite birth was an induced birth!

By Jay Kelly



Jay Kelly describes how the induction of her second baby was her favourite out of the 6 babies that she's birthed!

Don't get me wrong, I really do not like 'Induction', and I am not an advocate, but I do think it helps women to be able to hear about the induced births that turned out well.

The birth of my second baby was an unnecessary induction due to being "overdue".

If I knew then, what I know now, would I have done things differently? Yes.

I would have questioned the reasoning behind the induction, and I knowing what I do now, I would have said no.

But I didn't. I didn't know I could say no.

The reasons they gave for induction was that I was "2 weeks overdue", when in fact I wasn't even "overdue". I was made to feel like my body was failing me. I didn't know that my baby would have come anyway.

I was told that my placenta would fail the baby, and any delay would be risking her life.

If I knew then what I know now, I could have requested a Doppler scan, which measures the blood flow through the umbilical cord and around different parts of the baby's body. They can check to ensure the baby is getting all of the oxygen and nutrients they needs via the placenta.

My baby was still active, and I felt very tuned into her, but this would possibly have helped me feel confident with just waiting until my baby triggered spontaneous labour.

With hindsight I would definitely have said no to induction, but my hindsight isn't all bad, as the birth turned out well anyway… I do feel that I was lucky though.

With hindsight I would definitely have said no to induction, but my hindsight isn't all bad, as the birth turned out well anyway… I do feel that I was lucky though.

I feel lucky that despite the induction I experienced an Orgasmic Birth. I had no idea that was even a thing. At the time I kept it super quiet, didn't mention it to anyone, and hoped that my husband and midwife didn't notice.

I do wonder how much better it could have been if it was spontaneous labour. Probably less time and less intense.

For a little bit more insight into where this birth story fits in

context with my other experiences of birth, I will share a snapshot.

1st baby (7lb 6oz), spontaneous labour at 41+3, traumatic, epidural, 3x failed ventouse attempts, then forcibly removed from me by forceps and cord cut from around babies neck before her shoulders were even born. Such a badly handled birth. Full of fear.

2nd baby (9lb), pessary induced at 42 weeks, orgasmic birth… my favourite birth of all!

3rd & 4th babies (4lb 14oz & 6lb 1oz) Gel induction at 38 weeks. Birthed naturally, 10 minutes apart. Amazing birth. I now know that I can do anything.

5th baby (Surrogate pregnancy with embryo from the biological mother, ie not my egg - around the 10lb mark) 43 week induction (pessary, then synto drip, 3+ days of great unpleasantness, finishing in emergency cs). My least favourite birth to put it mildly.

6th baby (2nd surrogate birth, same parents, around the same weight as her sister.) Spontaneous birth at 41+3) Successful and very healing & empowering VBAC.

I went into my first birth very naively. I thought that the midwives would truly have our best interests in mind, and there was no point making birth plans etc, as I would just do as they told me anyway. It was the most hideous idea… so as I went into my second pregnancy, I made an effort to learn more about my body, the physiology of birth, sought out support, and made some better plans.

All that being said, I turned out to be very lucky too, as I had the best midwife I could have had at that point in labour. I had never met her before that moment. She just made me feel safe.

She believed in physiological birth, she believed in my body, in the dance between me and my baby, she believed in me, and she made sure that I knew it.

She listened to me, and acted accordingly. She made sure I was warm, that I had privacy, motivated me when I needed it, and allowed me to be quietly inside of myself when I needed to. She supported my husband to support me in the best way that he could do (by being distracted!).

Her support made the birth what is was. I spent the time between contractions resting in an exhausted upright stupor, but then during the contractions I spent my time reading the same 3 lines (warning sticker) on the electrical arm of the bed. I was resting over the back of the bed at the time.

I don't know how long that birth was. I think it was only about 12 hours from the pessary being put in, to my baby being born. But it felt far longer. It was probably only that short due to the fact that I had already birthed a baby previously.

The early stages really felt like forever. I remember the previous shifts' midwife doing a couple of vaginal examinations and telling me the same thing both time "unfavourable cervix, 2cm dilated. No real progress", and I remember how heavy my body felt when I heard those words. Those words triggered disappointment, lack of faith that I was capable of doing it right, they made my body feel like a lead weight, one that I was totally disconnected from my own body. My mind became busy, and full of self-doubt.

Then the shift ended and my midwife changed. The minute she walked into the room and introduced herself, I felt myself relax. I felt safe with her.
She asked if I wanted her to check my progress, and I agreed. She said something along the lines of: "Lovely. You are 2 and a half cm… great progress".

I know, I know… no one measures in half cm… and I knew that at the time too, but it didn't matter. What I heard was motivation, someone who cared about the words she was using. A midwife that made me feel like she had my back. Her words and positivity triggered something in me. A spark of hope, optimism, my body shifted, not sure how, but changes happened.

I birthed my baby within an hour of that conversation.

Never once did she say that I couldn't be ready to push, as she had only just checked my cervix, never once did she doubt me. She made a gentle suggestion to move, when I was pushing, and encouraged me to a new position and added a mirror, so I could see what my efforts were doing.
Then, with a huge orgasmic rush, my baby was born.
I slipped down onto the bed and drew my baby up to my chest. My husband didn't faint in this birth, as he was busy with the camera, capturing the very moment, when I pulled baby Eva up to meet me face to face for the first time.

As a birth worker, it still surprises me when I say that my favourite birth was an induced birth, but it's true.

Research Review

Women's experiences of induction of labour:

Qualitative systematic review and thematic analysis.

Coates, R. Cupples, G. Scamell, A. McCourt, C. (2019) Midwifery, 69: 17-28

by Gemma McKenzie

What was the study about?

The researchers wanted to understand whether there had been any studies undertaken which explored women's experiences of induction of labour (IOL). The goal was to find all of those relevant studies and to see whether there were any common themes that ran through women's accounts of their experiences.

Why did they want to do this?

Statistics show that the number of IOLs carried out in this country and abroad is rising. In the financial year 2016 and 2017, 29% of UK labours in English NHS hospitals were induced.[1] However, the vast majority of studies concerning IOL relate to the safety and efficacy of various methods, and very little refers to women's experiences. More recently, questions are being asked about where IOL should take place, with some UK trusts offering outpatient induction. The researchers felt it was important to understand women's views on IOL as their birthing experiences may impact on their relationship with their baby, their sense of self and their future reproductive decisions.

How did the researchers carry out the study?

The researchers created a set of inclusion criteria as to the type of studies they were interested in. This included, for example, studies that had been peer reviewed and those that relied on qualitative data, i.e. interviews with women. After setting these criteria, they then systematically searched a number of databases. They read the abstracts of potentially relevant studies, before deciding which ones satisfied their criteria and reading these in more detail. Only 10 studies were deemed relevant enough to be included in their review, and these dated from between 2010 and 2018. Five were from the UK, two from Australia, and one from Brazil, USA and Ireland respectively. The researchers then compared and contrasted the results of these studies and explored the recurring themes that appeared throughout.

What were the results of the study?

The researchers discovered four overarching themes:

1 Making decisions

All of the studies reported that women did not feel involved in the IOL decision-making process. Worryingly, some felt that information was withheld, while others stated that there was only minimal discussion with a health care provider (HCP). Nevertheless, women generally appeared to trust HCPs, with some women going as far as stating that they would never question a doctor.

In all of the studies, it was noted that women were concerned about the likelihood of further intervention once the induction had begun. Of interest is that in one UK study, women questioned why they were booked for an IOL based on an urgency to reduce the risk to their babies, only to find that once they arrived at hospital, they experienced delays in actually starting the process.

In six of the studies women had no clear understanding of why they were booked for induction. There also appeared to be a lack of understanding surrounding the risks associated with the procedure. In only one study did women report feeling prepared, with reference to an information leaflet and an opportunity to discuss IOL with their midwife being cited as important factors.

2 Ownership of IOL

In five of the studies women felt under-prepared for the IOL process. Some participants were unclear on how long the procedure would last, whether pessaries were given orally or vaginally, and whether their partners could stay with them. In four of the studies, women complained of feeling as if they were simply part of a checklist, and were moved around the hospital depending on what stage of the process they were in. Conversely, when women were induced as outpatients, they felt a greater sense of control.

3 Social Needs

Some women felt forgotten and alone yet recognised that midwives were rushed and so they did not want to pester them. Others complained of staff not believing they were in pain. However, in a few cases, these negative feelings were compensated for by compassionate care from HCPs during the process. Support from family and friends also fostered a sense of security, but the lack of privacy in hospital often meant that women did not feel that support as strongly. Women also expressed discomfort regarding the noises they made during labour while on a busy ward, and also complained of being disturbed by other women in the same situation.

4 Importance of Place

The hospital was seen by participants as noisy, busy and lacking privacy, yet also a place of security and safety due to access to HCPs and technology. Ward rules were not seen as favourable to women, with some reporting that their partners and family were forced to leave at various times, which left women distressed.

AIMS comments

At AIMS we are unsurprised at the results of this study. Medicalised induction in the hospital setting has been around for many decades, yet the amount of research conducted on women's experiences of the procedure is tiny. Notably, none of the studies in this review explored the long-term impact of IOL. Indeed, we believe such a study has never been carried out. This gap in the research demonstrates how our maternity system has lost sight of what should be central to the service it offers, i.e. pregnant women and their babies.

While this review only found ten recent studies on women's IOL experiences, there have been two much larger studies carried out in the 1970s that the researchers missed. Shelia Kitzinger carried out a study in 1975, and Ann Cartwright in 1979. There are some awful examples of mistreatment in these studies, including a practice whereby during vaginal exams, midwives pulled out tufts of the baby's hair to show the labouring mother.[2] A second example included only putting women on a syntocinon drip during office hours. This meant that when the drip was removed overnight, the woman's labour would slow, and she would be left exhausted and in pain.[3]

While these practices have now ended, many of those reported in the present study existed in the 1970s and still remain. This is especially true around the areas of decision making and consent. This evidence raises serious questions about informed consent and suggests that in these instances not much has improved over the last 50 years. Given that the process of IOL is now much more frequently carried out, it could be argued that the problems are getting worse.

One positive that comes from this study, and which appeared in the earlier two, was that compassionate care from HCPs makes a big difference to women's IOL experiences. At AIMS we believe that Continuity of Carer is the best way to foster a supportive relationship between a woman and her midwife, and in turn this may enable women undergoing IOL to have a more positive experience.

References

1 NHS Digital (2017) Maternity Statistics [online] Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2016-17

2 Kitzinger, S. (1975) Some Mothers' Experiences of Induced Labour. London: The National Childbirth Trust, at p.29

3 *Ibid* at p.25

Article

When HCPs can't see what their role should be

By Philippa Lomas

Supporting – not Suspecting – visually impaired parents can make the difference between trauma and joy.

Becoming a parent for the first time is a life changing and sometimes daunting time for any new mum or dad. For some parents, there are additional challenges. This is a true story, shared with permission.

Imagine you are a couple who are expecting their first child. This couple attend all their appointments with their hospital based consultant and midwife together. At the twenty week scan they discover that they are having a little boy. They are overjoyed!

One morning, shortly after this scan, there is a knock at the front door. Mum goes to answer it, and opens the door to a lady from the Social Services Safe Guarding Team.

Wondering if you missed something? Well, this couple are both visually impaired. But is this their additional challenge? Think about that for a moment. They have managed to get themselves to their appointments independently. They live independently with no outside help. They are used to their lifelong eye conditions and have learned to do things for themselves in spite of their visual impairments. So, why did the maternity staff call in the safeguarding team? Sadly, it's a theme that we are seeing more and more of. This particular couple had shown an interest in their midwife finding out what help might be available for them to go out as a family when their son was born. However, this was not what they received. Safeguarding services are not support services. This became their additional challenge, not their visual impairment.

After the social worker has gone, Mum sits down and confesses to Dad that she does not want to give birth to her baby because now she is frightened they will take him away. Many meetings follow with Social Services and midwives. They are all assessing how well the couple will cope when the new baby comes. Mum feels increasingly on edge and worried.

Mum develops high blood pressure, a condition not helped by the stress she's under, and before her due date comes she is in hospital being induced. It is a long and exhausting labour and when baby is finally born, he is placed on Mum's chest and latched on to feed. Take note of those two words: "latched on". Mum was not shown how to latch her baby, it was done for her. Next time baby is hungry Mum asks for someone to show her how to latch him on. "Oh, we'll latch him on for you," was the response. Mum replies that "I'd rather be shown so I can do it myself when we go home" but no one was sure how to help her because she couldn't see.

They advise that she hand expresses into a cup and syringe feeds it to baby. Hand expressing is not always easy at the best of times, without the two added complications of not being able to see well enough to catch the milk, and not being able to tell if the syringe has drawn up any air. So Mum has to give formula.

More often than not, I and my fellow peer supporters at Blind Mums Connect,1 hear many women's stories of being

told "you won't be able to latch the baby on because you can't see where your nipple is. It's probably best if you bottle feed." This is staggering! Before we resume our story of this couple, consider for a minute the steps that we take when making a bottle.

Step one, measure, for example, 2oz of boiling water into a bottle. Now imagine doing that with no sight, or very little sight. Even if visually impaired Mums are independent in the kitchen, making meals for the family, making their own cups of tea etc and the kettle does not frighten them, markings on bottles are not easy to read, even for Mums with partial sight. So how do you get round step one? Purchase a very expensive set of talking kitchen scales. Stand the bottle on the scales and set to zero. Pour in the hot water, without leaning on the bottle and adding extra weight to the scales, and very, very slowly so you don't go over the number of ounces required.

Step two, measure the formula. Measure a level scoop of formula without packing it down as you level it off. Pour it into your bottle. Made a mess? that's very normal. Now all you have to do is shake it and cool it. Simple wasn't it? No! And some visually impaired parents decide it's too hard, resulting in them buying machines such as the Perfect Prep, with all its added health risks, or asking partners to measure the water before they leave for work and stick it in the fridge, so all they have to do is warm the water up in the microwave and add the formula. Or maybe they'll ask them to make all the bottles and shove them in the fridge to be warmed as required. Don't misunderstand me, a lot of visually impaired parents make up bottles safely using the method of talking scales, and make them up as required, but for some it's just too much. Considering Mums produce milk at the right temperature and tailor-made for their own babies, making formula, with all its potential risks and variables, suddenly seems like more hassle than anything else, especially with the added complication of sterilising and making sure all bottles are clean of formula in the first place.

So let's get back to our couple. They have been in hospital a week now. They are both longing to be back in their own familiar surroundings where they can care for their baby independently but the hospital are reluctant to discharge them. Mum struggles to bond with baby because she is unsure how long she will be allowed to keep him. Dad steps in and does nearly all the work with baby.

The couple finally leave for home after their health visitor becomes involved and speaks to the hospital on their behalf. When they are home as a family, breastfeeding support is called in, but Mum's heart is no longer in it. She instead expresses for her son and gives it to him in place of some of his formula bottles. Her reason is that if she was breast feeding, the baby would be hungry if he was taken away. Social services visit again. At the end of the meeting the health visitor asks if she can come and visit again. When she was asked by the couple if she needed to come back, her response was "no". The couple told her that they did not want any more visits because the unnecessary stress and anxiety had spoiled the joy of the pregnancy and they didn't want the impending visits hanging over them to spoil their time with their new baby. There are so many eyes on this couple and none, apart from their health visitor, offered the support that they had asked for in the first place. The whole experience leaves the family shattered.

Sadly, there are so many cases of this now, and extra involvement is not always easy to shake off, with some parents being asked to look after dolls to prove they can look after a baby. How many sighted mums have to do this?

I am pleased to report that over a year later, Mum and baby have a strong bond and the family has healed. But their story is one that is now becoming more and more common.

There is no reason to assume that when you encounter a visually impaired mother or father that intervention is needed. Rather, taking a little time to get to know the couple would help you understand their basic needs throughout the time that you're supporting them. Of course, there are going to be exceptions to this, and at times extra support or intervention is necessary. But seeing a visually impaired parent shouldn't automatically cause the panic button to be pressed.

Here are a few examples of ways that healthcare providers can put visually impaired parents at ease:

- Say who you are when you walk into the room. This is vital, especially in hospitals or in birth settings. Just a cheery "Hi, it's just Anne again, come to see how you're doing," or if you haven't met someone before, "Hi, I'm Anne, I'm the midwife who will be looking after you today." It might sound very basic, but being in an unfamiliar environment is disorientating at the best of

times when you are visually impaired, let alone being in pain as well.

- Please say if you have brought anyone into the room with you. For example, "This is Doctor Smith, she's just come with me to talk about how things are going."
- Don't be afraid to ask how much the parent can see. If you don't ask, you won't know what support they might need, for example being shown round the room they're in to orientate themselves, or being assisted to find the toilets. People refer to their visual impairment in different ways. For example I'd say, "I'm totally blind, I can't see anything at all," whereas someone else with sight loss might say "I'm partially sighted, I can see things up very close." If you're unsure what term to use yourself, the term "visually impaired" covers all bases.
- If there is a fully sighted person with the visually impaired woman, please don't talk only to that person rather than the visually impaired person. Equally on the rise are stories of visually impaired Mums being given little support because they assume that their sighted person accompanying them to their appointment, be that their partner, mother, or next door neighbour giving them a lift, will be doing everything when she and baby go home. This cannot, and should not, be assumed. I have a wonderful, supportive family. My Mum or one of my sisters have accompanied me to all my hospital visits during my pregnancies. My Mum has stayed in hospital with me for days at a time as my birth partner. I have had support when I get home in the early days. However, I care for my child myself. Every time someone addresses a question to my Mum like, "How many wet nappies does baby produce in a day?" I want to shout, "Hello! I'm the baby's Mum!" Or someone will make a suggestion and then say, "Well you've got your mum to help you." While this is true, it doesn't take away from the fact I'm the parent. I'm the one who takes care of my baby day to day. Of course, there will be some families who will try and take over, and in such cases visually impaired parents need support to build up their confidence to do things themselves. Organisations such as Blind Mums Connect1 can help in various ways such as providing feeding support, assistance with slings and getting out and about.

Please don't assume that helping a Visually Impairedmum to breastfeed will be any more difficult than helping a sighted mum to breast feed. The mechanics are all the same. It might take some extra time, or a little bit of thinking outside the box if it's not working, but it is totally possible. Keep in mind that the cross cradle position is not the easiest for a visually impaired woman as it means she does not have any hands to feel when the nipple is opposite the baby's nose, and it can be quite frustrating and feel very awkward. Blind Mums Connect have peer supporters who can offer specific help with positioning.[1]

I have had very good experiences with midwives in hospital and with some of my community midwives. However, before my daughter's tongue tie was discovered, and it was decided she was not putting on enough weight, a nursery nurse came out to see me with my health visitor. She spoke to me as if I should be so grateful that she had made me her last call of the day to come and explain laid back breastfeeding to me. I was quizzed about the content of my daughter's nappy. "Does it have seeds in it?" when I explained that I didn't know, she said "Where's your Mum?" to which I replied, "I am 25 years old! I do not live with my Mum! She is not here 24/7!" She then asked, "Did you bath the baby yourself?" When I snapped back, "Yes, I did", she said in a very patronising tone, "That's amazing! and you dressed her too!" Needless to say, I did not take to her. Quite often, you see, the tone of voice carries a lot of weight for someone who relies on their ears rather than their eyes.

Health Care Providers dealing with vulnerable new parents have the ability to make a woman feel supported… or suspected. There is a big difference. Just by not making assumptions, providers could change the story for visually impaired parents, and allow them to enjoy their children with the same rights as fully sighted Mums and Dads.

Philippa Lomas is a peer supporter with Blind Mums connect, and a mother's supporter with ABM. [insert name of support role]. She is also the mother of two girls, and is visually impaired.

References:

Blind Mums Connect Website:
www.blindmumsconnect.org.uk
Blind Mums Connect Helpline: 01905 886252

Article

York's Homebirth Guidelines A Success for AIMS

By Emma Ashworth

Emma Ashworth updates us on the changes to the Homebirth Guidelines at the York Teaching Hospital NHS Foundation Trust – but there's still some way to go.

Back in 2018 I wrote about the horrific situation in York[1] where women were being told that they would be forced to accept interventions and tests in their home birth, including vaginal examinations, whether they wanted them or not, if they wanted their midwife to stay with them. York's homebirth guidelines were clear:

> *"If you arrive at the home of a woman and she refuses to allow you to access her home or to provide care to her, you must explain that you will need to leave and explain this decision to her."*

Women were being told by their midwife that they would not be allowed to decline any "care" by their midwife, which meant that they would be coerced into vaginal examinations rather than giving their free, informed consent. This means that the midwives were, by these guidelines, being forced to assault women, as unless we give our informed consent for access to our vaginas, we are being assaulted. Furthermore, midwives who chose to follow the guideline and leave if the woman declined an intervention or test, could be liable, should there be injury or death to the woman or baby, as could the Trust.

Despite over a year of discussions with the senior midwives at the Trust, they refused to accept that the wording of their guideline was leading to serious risks for women, babies, midwives and the Trust itself. A change of tactic was needed.

I wrote a letter to the Chief Executive of the Trust, which included the following:

> *"I am writing to make you aware of a guideline within the York Trust›s midwifery service which forces midwives to undertake a criminal act if they follow it, or put themselves at risk of sanctions by the Trust if they do not.*
>
> *[…]*
>
> *The guideline states that women attended by a midwife at a home birth must allow the midwife to undertake interventions or tests, or the midwife should leave the woman›s home. This means that women are being forced to concede to interventions such as vaginal examinations under duress, which is not giving consent in a way that the law requires. As I am sure you are aware, no one may put their fingers in a woman›s vagina without her consent (and coerced consent is not, in law, consent, in the same way that, for instance, coercing a woman to have sex is rape). To do so without consent is the criminal act of Common Assault (there is also a chance that it might be considered to be Sexual Assault). The midwife is also at risk of being sanctioned by the NMC for assaulting a woman. Furthermore, if a woman declines this intervention and the midwife leaves, any adverse outcome could lead to the Trust being held liable.*

The response from the CEO stated that women were not being forced into anything without their consent and that midwives were aware that they could not do this.

However, on the contrary, women had been reporting that they were in fact clearly told by their midwives that they would have no option but to consent to whatever the midwife wanted to do if they wanted them to stay. This is despite repeated reassurances from the Head of Midwifery that midwives were clear that the guidelines were not intended to mean this.

Despite his claim that there was no issue with the guidance, following my email to the Trust's CEO, updates to the guidance were provided to me in January 2019, with the following amendment:

> *" If you arrive at the home of a woman and she refuses to allow you to access her home or to provide any care*

for her, you must explain that you will need to leave and explain this decision to her. ***This does not include declining certain aspects of care such as vaginal examinations or auscultation of the fetal heart, which remains the woman's informed choice; but in situations where a request that no communication between you and the woman be made, no clinical care is to be given and/or the request that you sit in another room or outside the home as she labours with no access to her, providing no care." [Their emphasis]***

Although I was delighted that the amendments now mean that women are safe from being coerced into vaginal examinations, the Trust is still treating women who are birthing at home differently to those in hospital. I asked the Head of Midwifery why it was that the normal physiological processes of birth were not being supported by allowing women space and peace from interference when they wish to labour without speaking, or to have privacy to allow her hormones to flow. She explained that women who desired this in hospital would be supported and that their wishes would be respected.

She also claimed that the professional role of the midwife would be compromised if the midwife could not be with the woman – despite the fact that women are sometimes left alone for hours in the hospital setting, which clearly invalidates this argument. She said that the NMC would take a dim view of a poor outcome if the midwife had not seen the woman during her labour., I have contacted the NMC and asked what their position would be on this, and of a midwife deserting a woman in labour, and they were not prepared to make a statement either way. They would only deal with a real-life scenario sent to them as a complaint. Therefore it is not reasonable for Trusts to suggest to their midwives that their registration is at risk if they do NOT leave as the opposite is just as likely. Any reassurances from Trusts to midwives that the NMC would take one view or another is simply speculation.

For some women, having a midwife close by is what she needs to birth in confidence, but to invite a midwife into her birthing space who may well be a complete stranger could interfere with her labour, perhaps (although not always) due to previous negative experiences with health care providers, or maybe due to an assault in her past. Having a midwife who respects her birth space but is there if needed is the safest option for these women and their babies. If women in this situation need to choose between having a stranger in the room or not having anyone at all, the stress this causes can seriously inhibit labour and cause injury to the woman and possibly her baby. For many women, knowing that the midwife will respect her wishes and not force her to choose between no midwife and someone she doesn't yet know being in the room, leads them to, over the course of time, feel more confident in inviting them in.

If York were to implement a strong Continuity of Carer model as per the guidance from Better Births, this is likely to ensure that women are as comfortable as they can be having a midwife in their birth space. This will still not be right for everyone, but it would reduce the risk of harmful interference with the normal progress of birth. AIMS volunteer Katie Hickey's experience summarises the issue perfectly.

"In my first labour the midwives were on top of me the entire time. It's no wonder it ended in a c-section for 'failure to progress'!"

For the time being, the York Trust is not recognising the needs of some women, and it continues to force them to choose between two very stressful options – but only if the woman decides to birth at home.

The campaign continues.

References:

1 - www.aims.org.uk/journal/item/york-homebirth

Conference Report

Midwifery Today 17-21 October 2018, Bad Wildbad, Germany

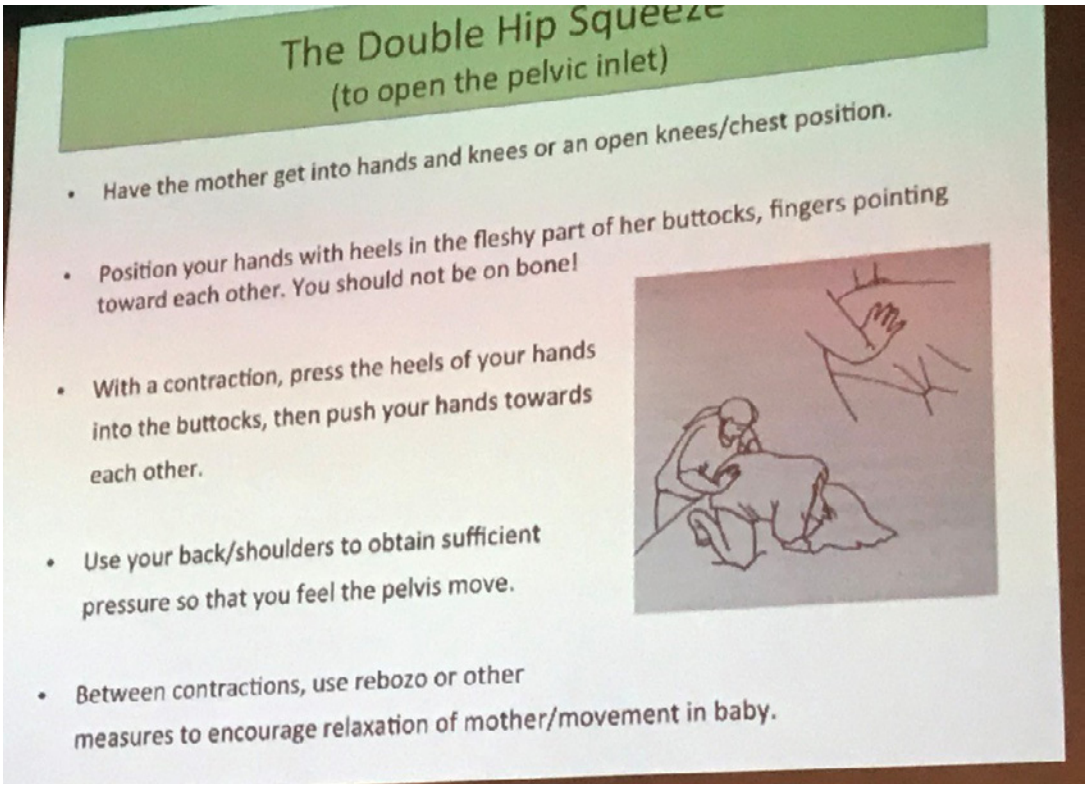
By Marein Schmitthenner

From 17 to 21 October 2018, I was lucky enough to be joining last year's Midwifery Today Conference in Bad Wildbad, Germany. Midwives, doulas and other birth workers from across the globe come together once a year for this extraordinary chance to exchange knowledge, learn new skills and meet the most wonderful people from all over our beautiful planet, who share the same values and goals: to make the birthing world a safer, happier, more respectful and more compassionate place for all women, their babies and their families.

It was a pleasure to witness the amount of knowledge, wisdom, passion, skill and experience this conference brought together. Information sharing ranged from Spinning Babies, shoulder dystocia, malpositions and placenta science to massage, waterbirth, spirituality, rebozo for pregnancy and birth, self-care for birth workers and much, much more.

We had the privilege to hear and learn from the most wonderful midwives and activists, including Elizabeth Davis, Cornelia Enning, Tine Greve, Gail Hart, Michel Odent, Debra Pascali-Bonaro, Elaine Stillerman and Jennifer Walker, to name but a few. During lunch, between talks and in the evenings, there was plenty of opportunity to meet many of the extraordinary participants: midwives from the Faroe Islands, rebozo teachers from the Netherlands, birth activists from China, and many other passionate believers in positive, empowering birth.

Elizabeth Davis, American midwife and author of 'Heart and Hands', taught us many old midwifery skills, like the proper double hip squeeze, when to use it and when not to, aspects of holistic Continuity of Carer and plateaus in labour. She campaigns in the USA to include all this knowledge in the universities' curriculum for midwifery courses. She said she would be very happy to help achieve this in the UK as well, where it is missing.



Gail Hart and Tine Greve talked about midwifery skills as old, traditional handicraft skills. One of their conclusions for breech births, for example, was to campaign for traditional breech midwifery skills to be included in the training of midwives and doctors, so that breeches will move out of the operating theatre and back into the birthing room. This, again, underlines the importance of talking to universities and course providers to add to their curriculum.

Information sharing ranged from Spinning Babies, shoulder dystocia, malpositions and placenta science to massage, waterbirth, spirituality, rebozo for pregnancy and birth, self-care for birth workers and much, much more.

Another very inspirational speaker was Vijaya Krishnan from India. She is a professional midwife and Lamaze teacher. Vijaya has developed a unique, collaborative model of care in her Sanctum Natural Birth Centre in India, which is midwife-owned and midwife-led, but supported by an in-house medical backup team, a paediatrician and a gynaecologist, when required. They even have their own operating theatre. This model does not deprive the so-called 'high-risk' mothers from having midwifery-led care, as they do not have to be transported elsewhere in case of an emergency, but can be attended to safely in the same premises in the presence of their midwife. This birth centre model has a medical team on call for on-site emergencies (no hospital transfers) and run many different antenatal classes, but the model can be re-created anywhere. The Sanctum and the 'Village Birth Centre' in India do take midwives from around the world for work placements/work experiences.

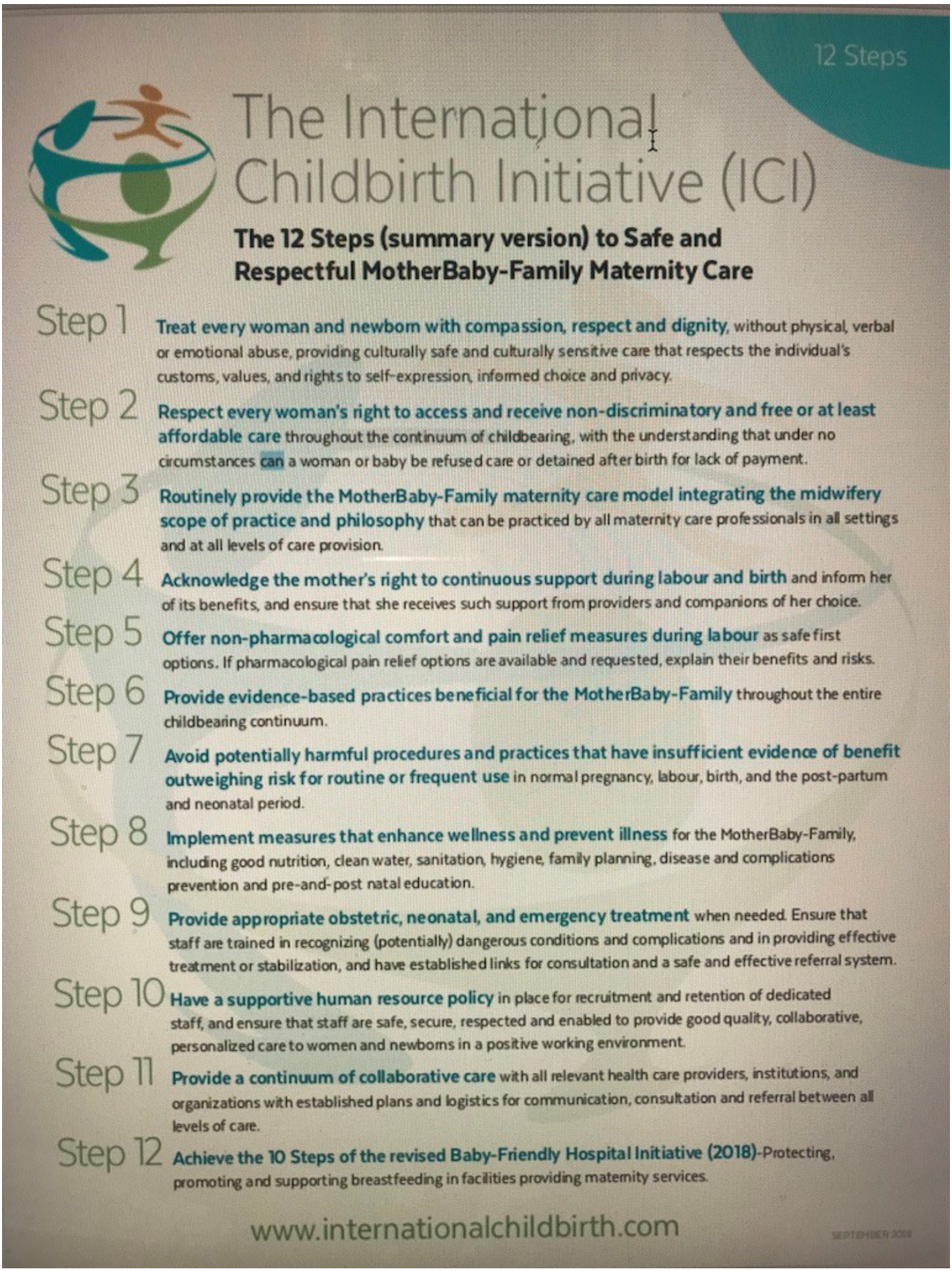
And then there is China. Meng Xue (Jenny) is a midwife with a passion and another truly inspirational campaigner for women. She founded the China Midwifery Alliance and has introduced huge, rapid changes to the maternity services in hospitals in China. Her organisation trains obstetric nurses, midwives and obstetricians in all fields of natural birth, from philosophy, naturopathy and homeopathy through to positions and physiology. It also provides antenatal classes to women and their partners covering all of the above. Jenny even trains the leading figures and managers of the hospitals. She and her organisation prove every day that change and training can start in one single hospital and spread from there by good example.

Last but not least, I would like to mention the International Childbirth Initiative. It was launched just before the Conference in October. Their website is *https://www.internationalchildbirth.com/* and it introduces 12 steps to safe and respectful maternity care. This list has been translated into various languages and is a very practical guide anyone can use to help improve maternity care in their area and beyond. (The graphic of the English version can be found on the next page.)

For me, the very last evening summed up what this conference was all about. A whole group of us met in the beautiful local spa where we sat naked in a hot pool (we were in Germany, after all) in all the glory of our female body shapes, chatted and laughed and then, magically, began to fill the colourfully tiled hallways and steamy rooms with song. The pure beauty and magic of these women's voices and their powerful and spiritual birth songs floating through the halls and over the pools opened my heart and soul to the point where I felt raw and vulnerable and strong and powerful, all at the same time. There was a sacredness in the air that should fill every birthing room in this world.

When everyone returned home the next day, to the airport, the train station or by car, the sacredness of birth and the intention to carry it out into the world was palpable (pun intended). Many wise women were born that week, some got wiser, most shared their wisdom. They all carry true hope for our births, our babies, our mothers and fathers and therefore our world.

Many wise women were born that week, some got wiser, most shared their wisdom. They all carry true hope for our births, our babies, our mothers and fathers and therefore our world.


12 Steps
The International Childbirth Initiative (ICI)
The 12 Steps (summary version) to Safe and Respectful MotherBaby-Family Maternity Care
Step 1 Treat every woman and newborn with compassion, respect and dignity, without physical, verbal or emotional abuse, providing culturally safe and culturally sensitive care that respects the individual's customs, values, and rights to self-expression, informed choice and privacy.
Step 2 Respect every woman's right to access and receive non-discriminatory and free or at least affordable care throughout the continuum of childbearing, with the understanding that under no circumstances can a woman or baby be refused care or detained after birth for lack of payment.
Step 3 Routinely provide the MotherBaby-Family maternity care model integrating the midwifery scope of practice and philosophy that can be practiced by all maternity care professionals in all settings and at all levels of care provision.
Step 4 Acknowledge the mother's right to continuous support during labour and birth and inform her of its benefits, and ensure that she receives such support from providers and companions of her choice.
Step 5 Offer non-pharmacological comfort and pain relief measures during labour as safe first options. If pharmacological pain relief options are available and requested, explain their benefits and risks.
Step 6 Provide evidence-based practices beneficial for the MotherBaby-Family throughout the entire childbearing continuum.
Step 7 Avoid potentially harmful procedures and practices that have insufficient evidence of benefit outweighing risk for routine or frequent use in normal pregnancy, labour, birth, and the post-partum and neonatal period.
Step 8 Implement measures that enhance wellness and prevent illness for the MotherBaby-Family, including good nutrition, clean water, sanitation, hygiene, family planning, disease and complications prevention and pre-and-post natal education.
Step 9 Provide appropriate obstetric, neonatal, and emergency treatment when needed. Ensure that staff are trained in recognizing (potentially) dangerous conditions and complications and in providing effective treatment or stabilization, and have established links for consultation and a safe and effective referral system.
Step 10 Have a supportive human resource policy in place for recruitment and retention of dedicated staff, and ensure that staff are safe, secure, respected and enabled to provide good quality, collaborative, personalized care to women and newborns in a positive working environment.
Step 11 Provide a continuum of collaborative care with all relevant health care providers, institutions, and organizations with established plans and logistics for communication, consultation and referral between all levels of care.
Step 12 Achieve the 10 Steps of the revised Baby-Friendly Hospital Initiative (2018)-Protecting, promoting and supporting breastfeeding in facilities providing maternity services.
www.internationalchildbirth.com

Conference Report

Clinical Guidelines: Litigation, Patient Safety and the Law Conference

By Beth Whitehead for AIMS

The purpose of the conference was to explore how evidence-based clinical guidelines are used by defendants, lawyers and the courts in clinical negligence litigation and in attempts to improve patient safety. It also showcased preliminary findings from the Guidelines Project team's (Dr Conrad Nyamutata, Professor Jo Samanta and Dr Ash Samanta) research on the topic before publication in February 2019. The project was funded by the British Academy/Leverhulme.

The confernce had a high calibre of attendees from a range of legal, medical and academic backgrounds. The day kicked off with a talk on informed consent and information disclosure by Rob Heywood, Professor of Medical Law at University of East Anglia. He referred to the case of Montgomery v Lancashire [2015] and the inconsistency in whether judges believe guidelines should have been adhered to or not.

Pritesh Rathod gave a lively account of a barrister's perspective on the use of clinical guidelines in clinical negligence litigation. There appears to be a trend of judges challenging medical expert opinions. The legal landscape is moving towards engaging patients in the decision-making process, valuing informed consent and considering individual cases rather than blind adherence to guidelines.

Legal director Laurence Vick gave a detailed explanation of the role of guidelines and protocols in clinical negligence litigation. He highlighted that in recent years there has been a proliferation of guidelines and protocols issued at local, national and international level by NICE, Royal Colleges, NHS Trusts and other organisations. While their aim is to facilitate best practice in a standardised way to ensure consistency of care, improving patient safety and minimising cost of negligence claims against the NHS, they may be vulnerable to challenge in court cases if not shown to be the product of an unquestionable decision-making process or if the process of dissemination and publication of a guideline is inadequate. Guidelines may be seen as one-size-fits-all, too prescriptive, restricting clinical discretion and being inflexible to the individual. In maternity settings, this approach causes a shift away from women-centred care by not including women in the decision making process fully through thorough conversations to support their autonomy.

I found the account by Dr Marwan Habiba, Consultant Obstetrician and Gynaecologist at the University Hospitals of Leicester NHS Trust, of guidelines and patient safety from a practitioner's point of view interesting. He highlighted the dilemma between prescriptive guidelines on how caesarean births are to be performed and the limitations of research and practice. Inconsistencies in gestational diabetes diagnosis criteria exist between different organisations and their guidelines. We need to be mindful of the different ways that guidelines are interpreted. If used prescriptively for clinical decision making, it means the individual's needs may not have been considered and it poses potential danger and ethical issues.

Guidelines may be seen as one-size-fits-all, too prescriptive, restricting clinical discretion and being inflexible to the individual. In maternity settings, this approach causes a shift away from women-centred care...

The project team gave a stimulating introduction to the hierarchy of guidelines (organisational versus regional versus global). There may be conflicts between these guidelines and

there can be inconsistencies between healthcare providers on which guidelines are used in practice. They also talked about how the NICE guideline can be used in practice as "a reasonable body of opinion" in mitigating risks of litigation. They gave a preliminary overview of the findings on their research on the various guidelines and the emerging themes.

In the afternoon, attendees were broken up into small groups to discuss different themes. These included the constraints on whether clinical guidelines can be followed; how can optimal use of clinical guidelines be facilitated, to what extent is clinical autonomy constrained by their usage, should failure to follow guidelines affect a legal professional's decision-making on clinical negligence cases and should healthcare regulatory bodies be responsible for promoting the use of clinical guidelines? There were some excellent discussions about the ethical and practical aspects of having clinical guidelines, their usage in practice and how practitioners try to deal with the volume and conflicting advice from guidelines issued by different levels of organisations.

A member of the audience with NHS and legal experience gave an example of how a patient was harmed due to a delayed diagnosis. There was lack of an incident register and risk management or investigation to rectify issues with process to improve patient safety and prevent similar incidents in the future. Another person raised the issue of when a concern is being investigated, sometimes the practitioners are not informed nor consulted of the matters so valuable lessons were not learned. They thought that some kind of incidents recording and shared risk register in the system would help to improve patient safety. Learning from mistakes to improve quality of care and safety can only be a good thing. It will increase public confidence in the healthcare system.

Dr Ash Samanta gave an example of how when an incident happens in the airline industry there are thorough independent investigations to ensure improvement in safety and high standards. However, when a member of the audience raised the issue of how there is significant lack of independence in investigating NHS incidents, he retorted, "Who is going to pay for it?" The reply was "taxation" and it was pointed out that users have paid for healthcare services already. Independent investigation can be valuable in improving patient safety and increasing public confidence as well as improving the culture of care and accountability amongst healthcare workers.

Another attendee asked Dr Ash Samanta for the definition of safety in their research, e.g. whether it encompasses psychological as well as physical safety but he simply referred to the NHS's definition which is "the avoidance of unintended or unexpected harm to people during the provision of health care". I was surprised at how vague and non-committal the NHS definition is. There is still a long way to go in terms of acknowledging the importance of compassion and body integrity in providing safety in health care. A well-rounded definition of safety is important in forming a foundation for framing and evaluating discussions about its improvement and around usage of clinical guidelines.

There is still a long way to go in terms of acknowledging the importance of compassion and body integrity in providing safety in health care.

Overall, the conference provided thought-provoking multidisciplinary discussions. This is much needed in communicating the difficulties and ethical and human rights issues medical and legal professionals face. It was a constructive forum in challenging practice models, clinical guidelines and care culture. More openness and independence are needed in the healthcare system. It will take working hand in hand with various health care providers and patients to improve safety and standards.

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Obituary

Philomena Canning, September 1959 – March 2019

By Marie O'Connor

Philomena Canning was a fearless advocate of the human rights of mothers in maternity care and of midwives in clinical practice. I first met her around 1997. She was a vibrant, passionate being, utterly committed to the project in hand.

Philomena strove tirelessly to transform Ireland's maternity care system, designed, as she saw it, to protect the private wealth–and public power–of consultant obstetricians, while denying midwives their status in European law as autonomous practitioners.1, 2 One of the earliest of the many international midwifery conferences we attended was on out of hospital births in Aachen, Germany, in 2000. That congress unanimously adopted the Aachen Declaration on Midwifery for All3. It called for midwifery to be reintegrated into primary health, for women to be offered continuity of care from a midwife of their choice in a setting of their preference, and for midwives to be given legal and financial parity of esteem with doctors as providers of maternity care.

Her Donegal roots may have contributed to Philomena's independence of mind. The third of nine children, she was born at home on 12 September 1959, in Glenvar, a Gaeltacht area in the beautiful, remote Fanad peninsula of County Donegal, in the far north-west of Ireland. Midwives had their title protected in law–a protection they were later to lose–and Philomena grew up hearing young Glenvar women talk with respect about their district midwives.

She trained as a nurse and midwife at the Whittington Hospital in London, later moving to Saudi Arabia to work, and thence to Sydney, Australia. Her experience of hospital midwifery there was not a happy one, and she successfully applied to run a health centre in Alice Springs for aboriginal women. There she spent four and a half years, helping women to give birth at home. Before she left, she was presented with a highly intricate, almost pointilliste, painting depicting birth, a fitting tribute to a revered midwife. Her experience in Alice Springs was to prove seminal.

On her return to Ireland she completed a master's degree in public health at Trinity College. However, the lure of clinical practice proved too strong, and Philomena entered the fraught field of independent midwifery in 1998 at a time when several other home birth midwives had effectively been forced out of practice.

Several of her clients took legal action in 2000 to compel the State to provide them with home birth services or reimburse the cost of private midwifery services4. The High Court refused the application for reimbursement on the basis that maternity services had to be provided by a medical practitioner, and that midwives were not medical practitioners. The central question, the State's legal responsibility to provide a domiciliary service, remained to be determined. Philomena's clients took action again5. Ending the statutory entitlement to a home birth service that had existed for half a century, the High Court held that the State had no legal obligation to provide home birth services and this decision was upheld by the Supreme Court. Costs were awarded against her clients.

In 2002, we co-founded the National Birth Alliance, campaigning for home birth services, setting up a web site, Maternity Matters, and making submissions to various bodies. The Competition Authority, for example, acknowledged that veterinary nurses were restricted in their practice by veterinary surgeons, but refused to accept that midwives were even more constrained6. The withdrawal

by the National Maternity Hospital of antenatal testing for the clients of independent midwives in 2003 sparked a new campaign: Philomena entered the fray with boundless energy and characteristic élan.

Philomena dreamed of opening an independent birth centre and prepared methodically for the venture. One month after rejecting her proposal, on 12 September 2014 (her birthday), the HSE summarily withdrew her indemnity, alleging risk in two births, despite being unable to identify any adverse outcomes. Her case became a cause celebre, supported by the Home Birth Association and AIMS Ireland, led by Krysia Lynch, who set up a group that included former clients to mobilise support. Philomena, who had some 29 clients at the time, applied to the High Court to have her insurance reinstated; the HSE countered with a conditional offer, which she rejected. She appealed to the Supreme Court: Expert reports, including one commissioned by the HSE, exonerated her practice. Ahead of the hearing in February 2015 the HSE offered to restore her indemnity pending a 'systems review' of the two cases and subsequently proposed to settle her case. Philomena refused, believing she had been blamed for a serious safety incident that the authorities had sought to conceal. She wanted the truth to emerge in open court. Sadly, ill health would eventually force her to settle.

A gifted midwife who lived for her work, she enjoyed a rich life outside it. Her siblings looked up to her and Philomena invariably took the lead in dealing with important family matters. She loved travel, clothes, food, theatre, music, and adored golf, although time did not permit her to play much.

A strong sense of feminism impelled her irrepressible activism. She inspired a younger generation of home birth mothers and midwives, relished public debate and was a frequent guest lecturer. In 2016, she co-founded Midwives for Choice with Ciara Considine, a former client, ahead of the referendum on the Eighth Amendment to the constitution, which gave the fetus equal rights with its mother. In Philomena's view the amendment had become a weapon that was used routinely against women to coerce them into unwanted medical procedures.

Philomena was persuaded by me to take part in the hearing of CEDAW, the UN Women's Committee in Geneva in February 2017 which examined, among others, Ireland's human rights record. She argued that 'active management' is premised on the denial of women's human rights, viz., self-determination, bodily integrity and personal autonomy. In its quasi-judicial concluding observations, CEDAW expressed concern at Ireland's reported policy 'of having 3 births per 24 hours for every bed in maternity wards', and called on the State to respect the natural birth process7. Philomena was particularly proud of this achievement.

She became ill in February 2018 and was subsequently diagnosed with ovarian cancer. An indomitable spirit, she showed a steely determination to carry on, speaking at the inaugural conference on human rights in childbirth in Dublin in April8 while undergoing treatment. Her final public appearance was in September 2018, when she spoke about the need to ensure that the new maternity hospital planned for Dublin would be publicly owned, not gifted, as planned, to a religious congregation. The Campaign Against Church Ownership of Women's Healthcare was to be her last.

Philomena is survived by her siblings, Mairead, Mary, Noel, James, Anne-Colette, Malachy and Oonagh.

Marie O'Connor
Chairperson
Survivors of Symphysiotomy

References:

1) Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. Official Journal of the European Union, 2005, L 255:22–142 Available on line at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:255:0022:0142:EN:PDF

2) The 2005 Directive combined and amended the original 1980 Directives:

Council Directive 80/154/EEC of 21 January 1980 concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in midwifery and including measures to facilitate the effective exercise of the right of establishment and freedom to provide services.

Official Journal of the European Union, 1980, L 033:1–7 (http://eur- lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31980L0154:EN:HTML); Council Directive 80/155/EEC of 21 January 1980 concerning the coordination of provisions laid down by Law, Regulation or Administrative Action relating to the taking up and pursuit of the activities of midwives. Official Journal of the European Union, 1980, L 033:8–12 (http://eur- lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31980L0155:EN:HTML)

3) The Aachen Declaration on Midwifery for All. Available on line at: www.collegeofmidwives.org/collegeofmidwives.org/Aachen%20Declaration%2000a.htm.

See also: www.collegeofmidwives.org/collegeofmidwives.org/safety_issues01/Aachen_progress01a.htm

4) Tarrade and Ors v Northern Area Health Board [2000/184 JR]. Unreported, 15th May 2002.

5) O'Brien and Ors v South Western Area Health Board [IESC] and [2003] 7 ICLMO 34.

6) See: http://homepage.tinet.ie/~maternitymatters/maternity_boys_beat_girls.htm

7) Committee on the Elimination of Discrimination Against Women 2017, Concluding observations on the combined sixth and seventh periodic reports of Ireland. CEDAW/C/IRL/6-7. 9 March 2017, 12-13 para 44-45. Available on line: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fIRL%2fCO%2f6-7&Lang=en

8) Human Rights in Childbirth Conference 2017 Mansion House Dublin. Co-organised by MacGeehin Toale Solicitors and Midwives for Choice. See: https://www.facebook.com/midwives4choice/videos/2091891417702326/?q=midwives%20for%20choice

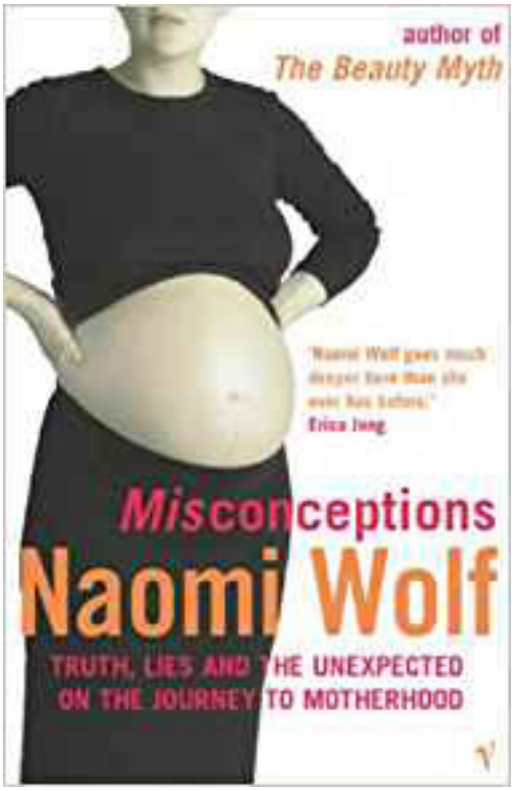
Book Review

Misconceptions: Truth, Lies and the Unexpected on the Journey to Motherhood

By Naomi Wolf

Vintage 2002
ISBN 0-099-27416-7
282 pages

Reviewed for AIMS by Marein Schmitthenner



This book, by the renowned feminist, writer and lecturer on women's issues, gender and politics, Naomi Wolf, is a truly feminist birth book. Even though it was first published 18 years ago it has lost none of its relevance for birthing women and mothers. It is honest and authentic from the very first page, and Naomi Wolf truly shines a light on everything that is tricky about women's experiences of childbirth in our culture today.

It is a must-read for all mothers and mothers-to-be and should be passed on to dads as well! It is not an easy read - in the sense that it is brutally honest and describes so very clearly the difficulty and trauma of giving birth and becoming a mother in a system so desperately lacking in compassion and respect for women and their babies. Naomi very clearly dares to make the link between women having babies and losing their status in their relationships and society, and she dares to speak about the traps and outright lies in our birthing system. She eloquently and beautifully tells the story of her pregnancies and births, and her stories speak for themselves. They tell the truth about the lack of true information, touch the inhumanity and false positives of many tests during pregnancy; inform about electronic fetal monitoring, epidurals and much more. Naomi is also brutally honest about post partum depression: 'It is not the depressed new mother who is aberrant; it is her situation that is the aberration.'

Brace yourself, breathe deeply, read it, and start your mothering journey truly informed, in the best possible way. With an open mind and heart and open eyes, full of the wisdom of the mums who came before you. This book shows so well how our world changes on our way to becoming mothers, as well as our perception, our feelings, our viewpoint and our frailty. It shows how we might begin to be properly supported and get rid of the burden of guilt we so often feel.

Do not believe this book will put your mind at rest. This book will wake you up in every sense - informationally, emotionally, spiritually - to the sacredness and wonder of birth and of becoming a mother, and why we as a society need to honour and treasure this journey a lot more than we do.

Finally, I love how this book puts a finger on something else I have felt for years: That our society still assumes that we women cannot take the responsibility of giving birth and being mothers and being faced with life-changing decisions. Oh yes we can, this book shouts, and rightly so! Just give us a chance to do it our way.

Marein Schmitthenner is a birth/postnatal doula and AIMS volunteer.

AIMS AGM
&
Volunteers Mini Retreat

When: 12th September 2019

Venue: Old Chapel Cottage, Belper, Derbyshire DE56 1AZ
http://www.derbyshire-holidays.com/cottage.php?id=oldchapel

It is a lovely part of the country and the house itself is a ten minute walk from Belper train station (which has good links to mainline train stations) and there is also some car parking available nearby. We hope that you will take this opportunity to join us to discuss our plans for the future and we will also take time out to cook together and relax.

We invite all our members to join us for the AGM on Saturday 14th September. Arrive 10:30 am for an 11:00 am start and we will plan to run the meeting through to 4 pm. But you would be most welcome to join us for breakfast and stay and eat with us in the evening. Contribution to a shared lunch would be appreciated.

Should you require any further information, wish to attend the AGM or to send apologies, please contact our Office Manager, Isabelle Pearcey (isabelle.pearcey@aims.org.uk).

We hope to see you in September!