Association for Improvements in the Maternity Services

AIMS Journal Vol:26 No:2 2014

AIMS

Long-term impact

10 things you need to know about induction

Julia Duthie's six-year pursuit of justice

Working to prevent female genital mutilation

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Diary

AIMS Meetings

Thursday 18 September 2014
London
Thursday 27 November 2014
Bristol
Friday 24 April 2015
Sheffield

All AIMS members are warmly invited to join us. For further details, to let us know you are attending or to send apologies please email secretary@aims.org.uk

AIMS Talks

Sara Wickham

Group B Strep

26 November 2014
Bristol

Mavis Kirkham
Thursday 23 April 2015
Sheffield

If you are interested in attending please email talks@aims.org.uk

MicroBirth

AIMS Screenings
20 September 2014
Confirmed screenings:
York, Huddersfield, Bradford, Cardiff, Swansea, Lancashire, Bristol, Liverpool and Cornwall
Other screenings to be arranged, more details and booking information at:
www.aims.org.uk/?microbirth.htm

Looking back to the future

Challenges and opportunities in maternity care
Tuesday 25 November 2014
Royal Society of Medicine
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LONDON
W1G 0AE

To register interest please email maternity@rsm.ac.uk

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founded in 1960
by
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AIMS

campaigning for better maternity services for over 50 years

AIMS

Hon President
Jean Robinson

AIMS Research Group
A group has been established to review research for the Journal. If you are interested in joining the team, please email research@aims.org.uk

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Journal Editor
Vicki Williams
email: editor@aims.org.uk

Guest Editor
Nadine Edwards

Journal Production Team
Beverley Beech
Gill Boden
Muriel Chvatal
Debbie Chippington Derrick
Nadine Edwards
Judith Payne

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Cover Picture:
AIMS Talk by Sara Wickham
Induction of Labour, May 2014

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Informing choice

AIMS continues with its usual activities, of which one of the most important is directly supporting women through its helplines. We are also working hard towards improvements in maternity services at a wider level, and we are currently responding to a raft of draft guidelines, including the new NICE Guideline on Intrapartum Care.

Group B Strep – New Book and Book Launch Talk

To complement our growing list of publications, AIMS is delighted to announce that Sara Wickham is currently writing a new book for AIMS, looking at the information and evidence around Group B Strep, which will be available in November. To celebrate the launch of this new book AIMS will be hosting a talk by Sara Wickham in Bristol.

Book Launch Talk – Group B Strep
The Watershed, Bristol BS1 5TX
Wednesday 26th November
7:00 - 8.30pm (Doors open 6:30pm)
Early Bird Tickets £25 (£18 for AIMS Members)
From 1st October Ticket will cost £30 (£25 for AIMS Members)
All tickets will include a copy of the new book which will retail for £8
See www.aims.org.uk/?SaraTalk.htm for further details and tickets

Am I Allowed?

Further talks are also being planned and we hope to bring you a book launch of the new edition of one of our key publications, **Am I Allowed?** with Beverley Beech in London in January. We are also planning a talk by Mavis Kirkham in April in Sheffield on the subject of women and midwives working together to improve maternity services.

We hope that the new edition of **Am I Allowed?** will be available before the end of the summer and pre-orders can be placed via the publications page of the website www.aims.org.uk/?pubs.htm

To be added to our talks mailing list so we can send you details of these and other talks please email us at talks@aims.org.uk

As well as organising our popular talks, AIMS is organising a series of screenings of the new film MicroBirth, see our diary on page 2 and the below.

New documentary 'MicroBirth' reveals the microscopic secrets of childbirth

This film builds on pioneering work which has been carried out by scientists, doctors and midwives over decades and which until now has remained on the margins of obstetric and midwifery knowledge, although some, such as Michel Odent, have worked tirelessly to bring this to our attention. Could the way we are born determine our future health and even impact the future of humanity? These are questions explored in a new feature-length documentary MicroBirth, to be released worldwide on Saturday 20 September 2014.

The film's co-director Toni Harman says, *'Caesarean sections are essential and often are life-saving. However, up until now, no-one has really looked into the long-term impact. This emerging research is painting an alarming picture in terms of future health across populations. There may even be repercussions for the future of humanity. And yet, up until now, I don't hear any alarm bells ringing.'*

Featuring prominent scientists from the UK and North America, MicroBirth warns that modern birth practices could be interfering with critical biological processes, making our children more susceptible to disease.

Recent population studies have shown babies born by caesarean have approximately a 20% increased risk of developing asthma, 20% increased risk of developing type 1 diabetes, a similar risk with obesity and slightly smaller increases in gastro-intestinal conditions such as Crohn's disease or coeliac disease. All of these conditions are linked to the immune system.

MicroBirth is an independent production by Alto Films Ltd. The film has been produced and directed by British film-making couple, Toni Harman and Alex Wakeford. They are parents of a six-year-old daughter, who was born by caesarean section. The film has been funded independently helped by an Indiegogo crowd-funding campaign www.indiegogo.com/projects/microbirth/

Over 700 grass-roots public screenings have been organised across the world for the simultaneous release date.

AIMS MicroBirth screenings

AIMS has secured funding for 10 licences to show this film around the UK, with screenings confirmed in York, Huddersfield, Bradford, Cardiff, Swansea, Lancashire, Bristol, Liverpool and Cornwall, all on 20 September 2014.

We have also been gifted an additional two MicroBirth licences, from One World Birth, and AIMS would like to extend a huge thank you for them.

For more information about the film please visit their website www.oneworldbirth.net/microbirth/ and for information on AIMS screenings please go to www.aims.org.uk/?microbirth.htm

Get Involved

If you are interested in joining our team, helping to organise events, reviewing books, commenting on research or anything else, we would love to hear from you. A full list of contact details for the committee is on page 2.

Beyond the moment of birth

Nadine Edwards looks at the potential long-term impacts of maternity care

Over very many decades, parents, health practitioners, researchers and others have worried about the impact of poverty of all kinds, pollution of various kinds, diet, stress and the use of drugs and procedures on pregnancy, birth and beyond.

There has been much outstanding work in this area, and too many extraordinary people to mention here: Alice Stewart comes to mind.[1] It took 25 years before Alice's work on the devastating impact of X-rays on unborn babies was finally acted upon. Sandra Lane's carefully detailed work,[2] on how poverty and poor environments are intertwined and impact negatively on birth outcomes, is crucial to being able to provide excellent care for mothers and babies (see a review of this book at www.longwoods.com/content/19580). Doris Haire, who, very sadly for the birth activist community, died in June this year (her obituary is in our next issue), was another remarkable activist who worked tirelessly to bring much-needed attention and research to some of the drugs and technologies most commonly used during pregnancy and birth. While she did a great deal to raise awareness about the possible negative impact of ultrasound on unborn babies, this remains an unevaluated technology: AIMS has recently published a paper on this which you can read on our website www.aims.org.uk. Doris also raised concerns about synthetic oxytocin, a drug which Michel Odent and Kirsten Uvnäs Moberg have also researched and written about extensively. Michel has examined the impacts of the environment, diet, drugs, procedures and more through his organisation Primal Health (www.primalhealthresearch.com) and Kirsten's books on oxytocin gather together much of the research in this area. Marsden Wagner, who also sadly died earlier this year (see page 23), unendingly supported good midwifery practice that reduces the likelihood of interventions and adverse outcomes.

Recent research has linked the use of synthetic oxytocin during labour to a range of potential side effects, including autism and ADHD[3] – attention deficit disorder (see page 19). Synthetic oxytocin is frequently used at the end of pregnancy to induce labour, as well as during labour to speed it up. While drugs and procedures can be life saving for mothers and babies, Sara Wickham's article on page 6 discusses some of the potential disadvantages of induction that women may not know about.

Concerns are now growing that some drugs and procedures have longer-term impacts than we previously realised – on the individual and even on generations to come. This is an expanding and much needed field of research. In 2013, an international interdisciplinary group of researchers, including midwives, published a detailed paper that covers a great deal of ground and research findings.[4] Its main hypothesis is that although labour and birth takes a relatively short time, it might be critical to our future health, and that the use of synthetic oxytocin, antibiotics and caesarean section might be particularly implicated in a range of conditions and diseases in later life: *'events around childbirth are also formative, with the potential for lifelong and even transgenerational health consequences'* and *'physiological labor and birth is finely tuned to generate optimal epigenetic effects for later wellbeing.'* The authors conclude that *'Many questions remain unanswered concerning epigenetic remodeling during the intrapartum period.'*

physiological birth has many long term benefits

The producers of the human rights of childbirth film Freedom for Birth, shown across the globe last year, have been working on a second film, Microbirth, due to be shown on 20 September. This film focuses on the potential for long-term, negative health outcomes relating to the use of synthetic oxytocin, antibiotics, caesarean section and formula feeding. Drawing on cutting edge research from leading scientists in the field, it makes an important contribution to the argument that physiological birth has many long term benefits to mothers, babies, families and future generations, and that we continue to medicalise birth at our peril.

In fact, as the Lancet series on midwifery[5] – published in June – and countless other papers and experiences show us, physiological birth is increased by thoughtful and skilled midwifery care from known and trusted midwives. These midwives need to be well supported themselves by a wider network of appropriate and well-resourced health and social care. Midwives working in this way should be applauded and encouraged, and not victimised as is sadly sometimes the case (see page 9). Let us hope that good midwifery practice and models, including properly resourced midwifery caseloading, will be increasingly and quickly introduced (see page 21).

Nadine Edwards

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Ten Things ...

I wish every woman knew about induction of labour by *Sara Wickham*

In modern western culture, most women know about induction of labour before they even become pregnant.

They know that it is suggested when it is felt that it would be safer for the baby to be born than to stay inside its mother, and I suspect many women know that one of the main reasons for recommending induction of labour is because pregnancy has lasted for a certain number of weeks and the baby is perceived to be 'overdue'. Many women will know a good few other women who will have had their births medically induced, and so they are likely to know that other reasons are sometimes given for this. These reasons include that the woman is older than average, that her waters have broken early and/or that she has a health problem or condition which is felt to necessitate the bringing on of her labour.

But this is not the whole story, and there are many, many other aspects to the decision that some women need to consider about whether or not to have their labour medically induced. I have spent the past few months writing about this topic, and the result is the recently published and completely updated AIMS book, ***Inducing Labour: making informed decisions***.[1] For the book's launch event in Bristol at the beginning of May, I prepared a presentation entitled **'Ten things I wish every woman knew about induction of labour'**. I didn't want to focus on the things (as above) that are commonly understood, but instead on some of the evidence, issues and implications that I think women are less aware of and might want to take into account when making their decision. There are, of course, way more than ten things to know, but my list was intended to serve as a starting point for discussion rather than to be exhaustive.

1. It's not like normal labour

This might be obvious to some people, but I know from experience that it isn't to others. Induced labour is very different from labour that starts spontaneously. Individual women's experiences vary, of course, but there are a number of key and interwoven areas of difference that are fairly universal. Firstly, a woman having her labour induced is given artificial hormones, which can create more pain more quickly than would occur in spontaneous labour. Synthetic hormones don't trigger the release of a woman's own natural pain-relieving substances as her own hormones would if she were in spontaneous labour, and they come with a range of possible side effects, which means a woman whose labour is being induced needs to be monitored more closely. The increased monitoring can lead to the woman being less able to move around, which can increase her pain and stress, and this can quickly lead to a woman feeling that things have spiralled out of her control.

2. It's painful

I started to cover this already in point 1, but there are even more and varied sources of pain that I think women deserve to know about before making a decision. For example, the contractions caused by prostaglandin gels or pessaries, which are often given as the first stage of medical induction, can become really sharp really quickly, but without having any measurable effect. This can have a negative effect on women's experiences, and it is easy to become tired and/or disillusioned more quickly than if they were in spontaneous early labour. Oxytocin-induced contractions can also be very strong, and there is often less time to get used to these than when labour starts spontaneously. In addition, the increased number of vaginal examinations and other interventions (such as the insertion of cannulas) can create additional pain or discomfort.

3. It's a package deal

I have written about this quite a bit on my website (www.sarawickham.com) so I won't repeat myself too much here, but the fact that I get asked so frequently whether women can have a physiological placental birth or decline monitoring and/or vaginal examinations if their labour is induced makes me think that this is not a commonly understood fact. It is not that anyone wants to prevent a woman from making the decisions that are right for her. It is that the drugs used to induce labour are powerful substances that block a woman's own hormones and that can cause problems for the woman and baby. It is the effect of these drugs that needs to be measured, monitored and compensated for in induced labour. If a woman is concerned that aspects of induction are not what she wants, then it might be better for her to consider whether induction is really necessary in the first place.

4. Stretching and sweeping isn't benign

Nowadays, many areas have introduced a policy of offering women a 'stretch and sweep' at a certain point in pregnancy in the hope that this will reduce the number of women who go on to have medical induction. Even if we ignore the assumption that all of the women who are offered induction will consent to having it, a stretch and sweep can cause discomfort, bleeding and irregular contractions, and in some of the studies the stretch and sweep intervention only brings labour forward by about 24 hours. The authors of the Cochrane review on this concluded that: *'Routine use of sweeping of membranes from 38 weeks of pregnancy onwards does not seem to produce clinically important benefits. When used as a means for induction of labour, the reduction in the use of more formal methods of induction needs to be balanced against women's discomfort and other adverse effects.'*[2]

5. 'Natural induction' is an oxymoron

This is another one that I have written about elsewhere, in an article that is freely available on my website,[3] but the gist is easy to summarise. Either we are awaiting spontaneous labour as nature intended, or we are trying to interfere and bring it on earlier than it would otherwise have occurred. Sometimes there is good reason to try to bring labour on, but if a woman takes castor oil or asks her midwife to do a daily stretch and sweep or picks any one of the range of things that are purported to bring on labour, then she is aiming to induce her labour with non-medical means. I am not saying there is anything wrong with that, but I think that, particularly because we exist in a culture that continually devalues women's bodily processes, it is important to be clear about what our intention is.

6. It is NOT the law

I was absolutely appalled to discover, part way through writing the book, that AIMS had received a call to its helpline from a woman whose midwife had said: *'We have to induce you twenty four hours after rupture of membranes. It's the law.'* The woman had agreed to induction and went on to have what she felt was a very traumatic birth. I wish all women knew that there are no laws that state what a pregnant woman must or must not do, and both AIMS and I are very concerned about this. Any practitioner saying such a thing should be reported to their professional body. Any woman who is threatened in any way or told something of this nature is welcome to contact AIMS for information and support.

7. It's not 'just a trickle'

I am always really concerned when I hear midwives and doctors using language that downplays the interventions that they are recommending, and I particularly dislike the terms 'trickle' and 'whiff' when used in relation to intravenous oxytocin (syntocinon). This is a powerful drug and needs to be respected as such. It can cause fetal distress, and in fact in some areas the practice is to keep increasing the amount of syntocinon that women receive until the baby reacts, and only then turn it down as it is considered that the appropriate level has been found. But even where this is not done and the syntocinon is only increased until contractions are effective, it is a drug that needs to be given respect and its potential effects should not be minimised by professionals, whether intentionally or otherwise.

8. Women don't fail. Inductions and systems do

This one pretty much speaks for itself. Induction doesn't always work, and this is not the fault of the woman. I wish I could reassure all women who have had an induction that was unsuccessful that there was nothing wrong with them or their bodies. This is another case where some of the language used in the maternity services really needs to be reconsidered.

9. The post-term risk is later, lower and less preventable than people think.

Figure 1 shows a table that I used in the presentation as well as the book, and it summarises the results from a study that looked at the risk of unexplained stillbirth in each week of pregnancy. If you look at the figures – and I would particularly like to invite you to compare the risks at 37 and 42 weeks of pregnancy – you will see that the increase in risk doesn't happen as early as some people believe, and that the increase is lower than is often implied. In fact, the outcomes experienced by women who awaited spontaneous labour and by women whose labour was induced were so similar that none of the individual studies that compared induction with non-induction were able to show a benefit to induction in their findings. It is only when all of the results for all of the studies are added together that it is possible to see a small difference. However, the quality of one of the

Figure 1

Cotzias et al (1999) looked at unexplained stillbirth in each week in relation to the number of ongoing pregnancies.

The risk of an unexplained stillbirth at 35 weeks was 1 in 500

The risk of an unexplained stillbirth at 36 weeks was 1 in 556

The risk of an unexplained stillbirth at 37 weeks was 1 in 645

The risk of an unexplained stillbirth at 38 weeks was 1 in 730

The risk of an unexplained stillbirth at 39 weeks was 1 in 840

The risk of an unexplained stillbirth at 40 weeks was 1 in 926

The risk of an unexplained stillbirth at 41 weeks was 1 in 826

The risk of an unexplained stillbirth at 42 weeks was 1 in 769

The risk of an unexplained stillbirth at 43 weeks was 1 in 633

Cotzias CS, Paterson-Brown S, Fisk NM (1999) Prospective risk of unexplained stillbirth in singleton pregnancies at term: population based analysis. BMJ 1999;319:287. doi: dx.doi.org/10.1136/bmj.319.7205.287

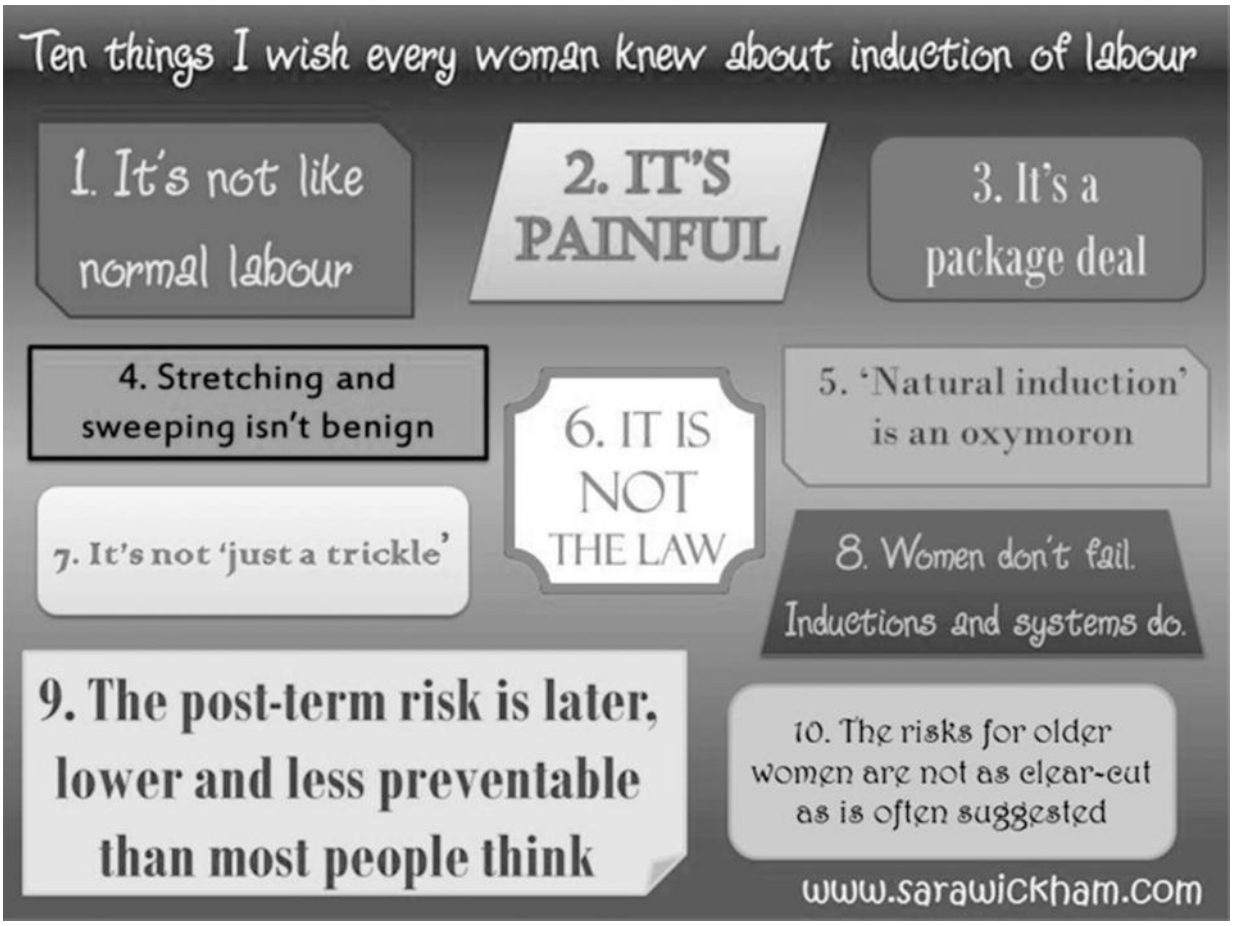

Figure 2

studies – which just happens to be the one that tips the scales – is really poor. For all of these reasons, it is really questionable as to whether current policies of suggesting induction for post-term pregnancy before 42 completed weeks confer any real benefit. There is lots more on this in the book, including a full analysis of the literature.

10. The risks for older women are not as clear-cut as is often suggested

My final point relates to the idea that women who are older are at greater risk of having a baby with a problem, and that they should be induced because of this. It is true that some studies suggest that there may be a correlation between increased maternal age and an increase in certain types of complications, but there are a number of reasons to be cautious about this. Women who are older are often offered monitoring and intervention in abundance, and this can cause complications. Older women are also more likely to have other health challenges (sometimes called co-morbidity) and it is hard to tell whether these problems and/or their age are the cause of any problems. The studies that have looked at this have not always separated these issues out, and the only papers that have done so looked at women who gave birth some years ago and who may not be comparable to women today. So there is a real lack of good data in this area, and unfortunately the studies that are being carried out to look further at this are tending to induce even younger women even earlier in pregnancy, so their results may not be of much use to women either.

A day or two after the talk, I asked some colleagues what would be on their list and, perhaps inevitably, they came up with all sorts of other things. In fact, there are not ten but literally tens of things that we wish women knew, but at least this is a start. You can find out more on most of these areas (and many more) in the AIMS book, ***Inducing Labour: making informed decisions***. Our focus now is on getting this information out to more women before they make their decision.

Sara Wickham

Sara Wickham is a midwife, teacher, author and researcher who has practised in a number of settings and worked in midwifery education, research and publishing. She currently divides her time between running 'Recipes for Normal Birth' workshops for midwives and birthworkers, writing books for AIMS, speaking at all sorts of birth-related events, undertaking consultancy projects and writing a twice-weekly blog at www.sarawickham.com, where many of her articles are freely available. Her most recent book is ***Inducing labour: making informed decisions.***

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Midwife Julia Duthie's case

Nadine Edwards reports on Julia's six year pursuit of justice

Over the last few years, AIMS has published a number of reports about the cases of experienced midwives with unblemished records who have found themselves defending their knowledge and practice before their UK regulatory body, the Nursing and Midwifery Council (NMC).[1,2,3,4] There are many more midwives who we know about.

There are also endless examples of midwives falling foul of their regulatory bodies and sometimes even being criminalised[5] in many high income countries. This is not a new phenomenon[6] and it is one we recently devoted an entire AIMS Journal to.[7] As we have said again and again, one of the reasons for this is the ongoing struggle between obstetric and midwifery ideology and where women's rights fit into this. It is clear from listening to some of the midwifery cases at the NMC that midwives' practice is often judged by medical standards and that supporting women's decisions where these fall outside these standards is seen as a failure to 'inform' them well and often enough to make the 'right' decisions.

This report on Julia Duthie's case is the most recent. And, as with other reports, if we were to include all that had happened in her case, the details would fill a book. But even the summary below demonstrates very clearly the difficulties just described. It shows inequity, impropriety, how unjust the regulatory system can be and how the careers and lives of experienced and conscientious midwives can be devastated. Independent midwives have been particularly vulnerable to these kinds of enquiries. For example, in this and other cases that we have witnessed, there have been obvious negative comments made and biases against independent midwives and judgements appear to have been made before evidence is heard. A letter sent to the NMC regarding the hearing is included on page 12.

The impact of years (in Julia's case, six) of fighting to clear one's name and practice cannot be underestimated. Negative consequences for these midwives are too numerous to debate here, but include the destruction of relationships, the introduction of fear-based midwifery practice, a decrease in midwifery knowledge and skills (as many fear practising outside protocols and guidelines), a decrease in respect for women's circumstances and their decisions, and a negative emotional and financial impact on the midwife and her family.

Chronology of events

19 June 2007 A pregnant woman expecting her second breech baby phones Julia. Her first baby was born by caesarean section – and although the baby was well, the baby's head got stuck during the caesarean and a drug had to be given to relax her uterus. She was given Julia's number by her Community Midwife because her local hospital does not support vaginal breech birth. Julia suggests that the woman visit another hospital 20 miles away as she knows that vaginal breech births have been supported there. Julia explains that although she has completed extra training to attend breech births, she had not yet done so in a homebirth setting.

26 June 2007 The woman phones Julia again, wanting to meet.

4 July 2007 Julia meets with the woman and again suggests the second hospital.

25 July 2007 The woman phones Julia while she is on holiday. She is in the 36th week of her pregnancy and leaves a message saying she'd like Julia to be her midwife.

6 August 2007 Julia books the woman on her return from holiday and says she will do her best to find a second midwife with breech birth experience. Over the next days and weeks she contacts 24 midwives and enquires via the independent midwives group, IMUK. No-one is available due to summer holidays, or being on call and living over three hours away.

Over this time, Julia is also communicating with Maria Patterson (MP), Supervisor of Midwives and Community Matron in the woman's locality, who Julia knows and who is supportive. MP looks into providing support as Julia lives an hour from the woman. MP says that the woman can call the hospital if necessary and someone will come out, and that if Julia wants a second midwife, the Supervisor of Midwives on-call will come. Julia again suggests that the woman visit the hospital supportive of vaginal breech birth and is happy to support her there.

13 August 2007 The woman makes an appointment to visit the second hospital and meet the Delivery Suite Co-ordinator/Supervisor of Midwives, Carol Axon (CA) and a doctor. Julia receives a call from CA to say that the woman has cancelled; CA also emails MP to let her know.

14 August 2007 Julia visits the woman who tells her that she cancelled the hospital visit because her young daughter would not be allowed into the delivery suite because of the noise of other women. As the woman is using hypnotherapy and wants her daughter nearby (the second hospital is 20 miles away from her home), she decides she doesn't wish to give birth there.

17 August 2007 CA at the second hospital says she is experienced in breech births and invites Julia to meet with her and go over some scenarios.

22 August 2007 Julia visits CA to demonstrate what she would do in various scenarios. CA later writes to the LSA Midwifery Officer, Val Beale (VB) and says that Julia is well informed. Julia discusses the woman's case with CA and lets her know that the woman does not wish to have any vaginal examinations (VEs). As Julia leaves, CA asks if she can send Julia a write-up of their meeting and Julia agrees. [This is later used by CA to claim that Julia agreed to her sending a supervisory plan of support, i.e. a care plan for the woman.]

22 August 2007 MP, Community Matron at the local hospital, leaves the woman a phone message and writes to her to ask if she can visit her at home.

23 August 2007 MP visits the woman and is the first person from the NHS that the woman likes, trusts and feels supported by. A plan is agreed.

24 August 2007 Julia receives an email from CA saying, *'As agreed, I have written a Supervisory Plan of Support.'* It includes four-hourly VEs, despite Julia having explained that the woman does not agree to VEs. CA also tells Julia in the care plan to pre-warn the ambulance service about the forthcoming birth, but when asked for the non-emergency number by Julia, CA replies by email that she does not have it. [It is not usual practice in either area to pre-warn the ambulance service. They say it is pointless as they will not keep an ambulance on standby; the only valid reason is if the post code will not find the place. In the event, the ambulance, when called, arrives promptly within eight minutes.] Julia contacts MP and is told that the hospital switchboard would be able to put her through to the ambulance service. [When Julia calls on her way to the birth, the switchboard operator is not able to put her through and does not have the number. Julia explains this to CA the day before the baby is born. CA finally sends the number to Julia the next afternoon, whilst the woman is giving birth. This becomes one of the allegations in her NMC case – that she did not pre-warn the ambulance service.]

24 August 2007 The woman phones Julia after having had a scan. The woman reports that all is well, the placenta and baby are in a good position but the weight of baby is estimated at 10½ pounds. The woman is upset because the obstetrician is graphic about the problems this could cause, says that the risk of scar rupture is five times more and talks of *'rivers of blood'*. Julia suggests contacting Mary Cronk, a midwife and expert in breech birth. The woman also reports to Julia that she has received CA's care plan, on the same day as Julia. They discuss the care plan on the phone. The woman is using hypnotherapy, she does not want to be asked questions, so in terms of Julia being aware of possible signs of scar rupture, the woman agrees that she will report any scar pain. Julia is used to avoiding VEs, so is supportive of the woman's wishes to avoid them.

24 August 2007 MP puts herself on-call for Julia and the woman over the Bank Holiday long weekend, after which a few Independent Midwives will be available to be a second midwife. MP has also done extra training in breech birth, but has not attended any.

28 August 2007 Julia visits the woman, who has spoken with Mary Cronk. Mary is generally positive about large breech babies, as this means the large bottom makes plenty of room for the baby's head, and that if the baby's bottom does not descend in either 1st or 2nd stage of labour a caesarean section is advisable. The woman is happy with this.

2 September 2007 Julia phones the woman to see how she is as she has been 'niggling'. The woman is worried about 'niggling' in case it is a sign that a caesarean is needed as Mary Cronk explains that a stop start labour is a sign that a caesarean is necessary. Julia offers to visit, sets off for the woman's home and on the way phones the second midwife to say that the woman is considering a caesarean section and that she might not be needed. Julia informs the woman that she can still have a positive birth by caesarean section, but the woman decides against this. Julia suggests to the woman that they talk to Mary Cronk. Mary's response is that the 'niggling' isn't a warning sign, it's her body preparing for labour; but that once in established labour, if it stops, this is an indication for a caesarean section. The woman calls Julia that evening to say her waters have broken and Julia goes out to her. Julia phones CA and the second midwife (who lives two hours away). Julia arrives and all is well with the woman and the baby. Julia remains at the woman's house overnight, though labour is not yet established (because she lives an hour away).

3 September 2007 Next morning the woman and her husband are happily using hypnotherapy techniques and do not raise the subject of transferring to hospital. [In her evidence three years later, the woman says that she had been asking to transfer to hospital for a caesarean section.] The second midwife goes to a friend's house.

By 2pm the woman is in established labour and Julia asks the second midwife to return. She phones CA to let her know what is happening. CA asks if Julia has performed VEs. Julia has not and CA asks her how she will obtain a baseline for the woman's labour. Julia explains that her contractions have increased from being irregular and one to two in ten minutes, to regular and three in ten minutes, and that changes in the baby's position and other signs will indicate progress. If in four hours she feels that there has been no progress, she will recommend a VE to the woman. [Later, in her statement, CA claims that Julia said she would carry out a VE immediately following the phone conversation. In the event, the baby is being born and the ambulance has been called before four hours have passed.]

By 3pm the second midwife returns and the woman is doing well using hypnotherapy, with her husband providing prompts. She is kneeling and Julia listens in to the baby every 15 minutes. The heart rate remains within normal limits. The bag of waters becomes visible, then the baby's knee, then the legs are born. The baby's navel appears and there is a large, fat cord. [Julia has photos of this as the woman wanted a camera to be used. These are later used as evidence when VB (the LSAMO who referred Julia to the NMC and who the NMC uses as their expert witness at the hearing) claims that a knee presentation is an indication to immediately call an ambulance. This is not the case and the photos show all to be progressing well, with no reason to call an ambulance.] All continued to be completely normal, with good colour, tone and progress until the baby's upper body becomes visible. With the next contraction Julia expects the baby's arms to appear, but sees nothing. She feels for the baby's arms, they are not in front of the baby's chest or face, but behind the baby's neck. The Løvset manoeuvre (turning the baby) is the correct procedure when this happens and Julia attempts this to no avail. She then tries another manoeuvre to try to free the baby's arms. Within 60 seconds of finding the arms behind the baby's neck, Julia asks the second midwife to call an ambulance and the hospital, which is a mile and a half away. She does this.

The Supervisor of Midwives at the hospital wants to talk to Julia while she is working to free the baby, so the second midwife holds the phone to her ear. The supervisor offers to send out support and Julia expects a doctor to arrive. Twenty minutes later, two Supervisors of Midwives arrive and refuse to help with manoeuvres to free the baby. By this time, the baby's arms are out, but the head is not. Julia and the second midwife continue to try to free the baby. Julia is aware the baby has died.

As soon as the baby is born the NHS midwives start resuscitation, which continues in the ambulance. [Later the two midwives are called as witnesses and both appeared to have forgotten that Julia assisted with the resuscitation.] Julia goes in the ambulance with the baby, as she is still assisting with the resuscitation, and the second midwife follows in another ambulance with the mother. In the hospital a doctor continues with resuscitation to no avail. He then tells the husband that his baby was stillborn. The husband joins his wife while she is being sutured and asks Julia to stay with their baby so that he is not alone. The second midwife joins Julia.

After suturing, the baby is taken to the woman and her husband and they invite Julia and the second midwife to join them. The woman states that she is happy that she gave birth at home.

4 September 2007 Julia is suspended by the LSAMO (VB) for not following CA's care plan. Julia phones CA to tell her what VB has told her. Julia has in fact carried out the plan, except for pre-warning the ambulance service, which CA was aware of 20 hours before the birth. The recommended four hourly VEs in established labour were irrelevant because the woman was in established labour for less than four hours and had declined them. CA says she cannot talk any further as she will be part of the investigation and says that this will done by a Supervisor of Midwives from another area rather than by VB. [However, VB does carry out the investigation.] Julia visits the woman in the evening and she and her husband are both shocked and upset that Julia has been suspended. Julia asks VB if she could meet as soon as possible, so that she can describe events.

6 September 2007 Julia visits the woman at home (she continues to visit the woman each week until November and then fortnightly until mid December, to support her). The woman invites her to the baby's burial on 27 October. At Julia's last visit in December, the woman gives her a beautifully wrapped rose quartz heart.

12 September 2007 VB meets with Julia in Julia's home. She informs her that the investigation has to be completed within 20 days. [It takes two months.] She interviews Julia and leaves saying that she will need a statement from Julia at some point, but later fails to request one.

5 October 2007 Julia becomes aware that she has been suspended illegally. VB had suspended her (under an obsolete rule) pending a decision on whether or not to refer to the NMC. As this is outside the regulatory framework (which only permits suspension with referral to the NMC), it is difficult to challenge and repeated enquiries by Julia and her husband to the NMC result, perversely, in the NMC pressing VB for a formal referral.

11 October 2007 In response to pressure from the NMC, VB emails, formally notifying the NMC that she has suspended Julia and is completing her investigation and will send a referral within 14 days. [At this point she still has two key witnesses to interview and at no point does she talk to the woman.] Julia's name is removed from the NMC online register – even though the NMC has not received VB's report and the NMC is aware that Julia's suspension is illegal.

22 October 2007 Julia sends a pre-action letter for judicial review to the LSA and the NMC regarding her illegal suspension.

25 October 2007 Julia receives a letter from the NMC saying that VB's complaint has been received, but that it will be dropped if it does not receive the full referral by 31 October 2007 and Julia's name will be returned to the online register. The letter states however, *'that would not in itself cancel the LSAMO suspension.'*

26 October 2007 The LSA's lawyers reply saying Julia's unlawful suspension has been revoked. They admit fault and agree to pay Julia for loss of earnings over that time.

30 October 2007 VB formally suspends Julia and makes a referral one day before the deadline. She has not interviewed the woman or come back to Julia for a statement or to gain more information about the contradictions between Julia's and CA's version of events. The allegations in the referral are based on CA's evidence. Julia is given no opportunity to comment on these until three years later, by which time the woman has changed her story.

31 October 2007 Julia begins to prepare for her NMC Interim Order hearing where an NMC Committee will decide whether or not to continue her suspension.

25 November 2007 The woman sends Julia a very supportive email to give to the NMC and a copy of an email that she has sent to her MP asking for his help in shining a light on the injustice and scapegoating of Julia. [Both of these emails were read into the public record in their entirety by Julia's barrister during the hearing.]

27 November 2007 On the day of the Interim Order hearing the NMC has still failed to find a 'due regard' midwife member for the Panel, so phones round to find someone.

This results in a less favourable 'due regard' midwife for Julia as this midwife has not had a chance to read the large bundle of papers thoroughly and does not specialise in homebirth. Finally, in the afternoon when the case begins, the NMC lawyer, Mr Hafejee, reads out confidential, personal information about the woman from the bundle of papers, which everyone had been told not to share. A member of the press is clearly in attendance at this hearing and these details are reported in the woman's local newspaper two days later. Julia is unable to give her side of the story at the Interim Order hearing, as *'this is not a fact finding exercise'* but based on the initial allegations. In this case, these are based on CA's statement, so the NMC decides to continue VB's suspension of Julia with an Interim Suspension Order. Suspensions are required to be reviewed at set intervals, but this does not always happen.

29 November 2007 Julia visits the woman unaware of the newspaper article. The woman shows it to her and then marks up inaccuracies and says she will talk to her MP about it. The woman feels she can no longer walk down the street without thinking that people know private things about her. Had Julia known that she could have applied to have had the hearing in camera (in private with no members of the public or press present), she would have requested this, but she was not informed about this possibility. She does request all future Interim Order hearings to be in camera, in order to protect the woman.

21 May 2008 Interim Order hearing. Julia's suspension continues.

3 September 2008 Interim Order hearing. Julia's suspension continues.

17 December 2008 Interim Order hearing. Julia's suspension continues.

22 April 2009 Interim Order hearing. Julia's suspension changed to Conditions of Practice because Professor Lesley Page gives evidence, having written an Expert Report showing that there has been a systems' failure within the NHS. Following this hearing the Conditions of Practice are seen as unworkable, as they are understood to mean that Julia is to be under a supervisor with experience of high-risk midwifery care whenever she practises. This is referred back to the NMC for another hearing.

A letter sent by concerned attendees at Julia's hearing

Dear Mr Weir-Hughes

We attended Julia Duthie's Fitness to Practice hearing on 20 August and were shocked and disappointed at the behaviour of Val Beale, Local Supervisory Authority Midwifery Officer, and accompanying witnesses including someone we believe to be Supervisor of Midwives, Carol Axon.

On arrival we were asked to wait in a lobby area before being shown into the hearing room and we sat ourselves at a table. We were approached by Carol Axon, Val Beale and another woman who discussed the case with us without first verifying who we were.

The women expressed very negative opinions about independent midwives in general, Julia Duthie in particular and Julia Duthie's barrister who was called a bitch. We found this to be totally unacceptable and unprofessional behaviour, especially as they had no idea who we were. This is breaching confidentiality and also behaving in a way which is detrimental to our profession and clearly shows disregard to the fair processes that the NMC should be adopting when investigating and hearing this case.

It also prejudices and contravenes the standards that the NMC and LSA's have in statute. We had hoped that supervision was moving away from being punitive in light of recent NMC guidance; however what we witnessed has made us feel that supervision is inequitable and is prejudiced and biased. It also breaches the standards of supervision 3.1 and 5.8 which speak about using proactive support for midwives and supervisors being innovators and leaders of midwifery and "Modern supervision in action" which speaks about the support and guidance that midwives should expect from supervision.

We chose not to identify ourselves to the three women, but tried to keep a distance throughout the day which proved very uncomfortable especially as they were giving each other 'signals', 'looks' and 'rolling their eyes' at evidence they did not agree with. It was also quite off-putting that Val Beale spent considerable time texting throughout the hearing.

We hope that you will take our concerns seriously.

Yours sincerely
Concerned Midwives [names withheld for this publication]

And the reply from the NMC

Dear Concerned Midwives

Thank you for your email for Professor Weir-Hughes' attention. I am responding on his behalf as he is currently out of the country on NMC business.

I am sorry that the behaviour you witnessed at the hearing has caused you to contact us. Sadly, yours was not the only report that we received about the behaviour of some observers at this hearing. Our hearings are extremely serious events with potentially very serious implications for registrants and it is indeed troubling that an observer, and particularly one from a professional background, was reported as behaving in this manner.

From speaking with my colleague who was present throughout this hearing, I understand that the chair of the hearing was also moved to reference Ms Beale's behaviour on Tuesday. I understand that he has spoken on the record about Ms Beale's conduct at the hearing and that this has been recorded in the meeting's transcript.

While we make efforts to remind observers that they need to comport themselves appropriately in a hearing setting, it can sometimes be difficult to monitor this at all times. We are, though, working on a clearer set of instructions to observers on the standards for behaviour required of them and your report of this particular incident will certainly be used to help us in this work.

Given the seriousness of your allegations, I will investigate the reported comments by the midwives that you have identified so that we can consider what, if any, further action we may take.

Thank you again for drawing this issue to our attention and contacting the NMC.

Yours sincerely
Peter Pinto de Sa
Assistant Director, Office of the Chair and Chief Executive
Nursing & Midwifery Council
23 Portland Place, London, W1B 1PZ
www.nmc-uk.org

20 May 2009 Interim Orders can only last for 18 months before having to be referred to the High Court to ask for permission to continue. The High Court judge allows an extension of a further 12 months on the understanding that the NMC clarifies the ambiguity in the Conditions of Practice within a month.

18 June 2009 An NMC Panel clarifies the Conditions of Practice so that they are workable. This takes many months to put in place because Julia has to find a new Supervisor of Midwives. The Head of Midwifery says that the local supervisors are too busy and involved in the case, so can no longer provide supervision. Eventually, Professor Paul Lewis, who works in a different Trust, offers to be Julia's supervisor.

4 November 2009 Julia receives a letter of referral to the NMC Competence and Conduct Committee and a list of allegations.

9 June 2010 Julia's lawyer applies for a cancellation of the hearing due to lack of evidence, as the NMC will not be presenting oral evidence from the woman. Julia's lawyer argues that, without this oral evidence, the NMC will not be able to support its allegation that the registrant's fitness to practise is impaired by reason of misconduct and that the hearing should not be held and the matter closed. This is not accepted by the NMC and it responds by adding extra allegations, and gets the woman and her husband to agree to give evidence (the woman via a video link). These extra allegations use a great deal of the Panel's time but are later thrown out, disproved, or do not amount to misconduct.

28 July 2010 A pre-hearing meeting takes place to object to the NMC using VB (Julia's LSAMO who investigated the case locally and referred Julia to the NMC) as the Expert Witness. The objection is overruled by the NMC Panel.

16 August 2010 The 10-day hearing begins. The NMC does not present oral evidence from the second midwife who was present at the birth as the hearing is at a time when she had previously said she would be unavailable. The case is not completed and a date is set to resume the hearing on 3 November for a further eight days.

12 November 2010 After eight days the case is not completed but adjourned, so that the Panel can decide if a sanction should be imposed. Meanwhile the NMC barrister puts a case for Julia being re-suspended and this is accepted by the Panel.

21 February 2011 At this one-day hearing, three of Julia's clients give evidence in support of Julia. The case is still not completed, but is again adjourned – until 8 March.

8 March 2011 The case is finally completed. Julia is struck off and a Suspension Order made as Julia's legal team has already stated that it will appeal the Striking-off Order.

Appeals to the High Court have to be made within 21 days and are costly, but Julia's legal funding ran out in November 2010. As Julia is her family's main earner, her income is by now so low that she is entitled to claim legal aid. This takes two appeals and her income being scrutinised before it is agreed. Despite applying within the 21 days, it takes 14 months to get a date for the High Court hearing. Meanwhile, Julia is unable to work.

1 May 2012 Julia's High Court three-day hearing begins.

31 October 2012 Julia finally receives the High Court's judgement. The judgement revokes the NMC decision and points out where mistakes have been made. It revokes the Striking-off Order and returns Julia to Interim Conditions of Practice. It throws out parts of the charge because it says that the NMC Panel came to the wrong conclusion in weighing up the evidence. The Court is unable to throw out the remaining proven allegations, but states that they had no impact on the outcome and requests that a fresh NMC Panel should consider these.

8 July 2013 The NMC begins to offer dates for a hearing. This is finally set for 12-14 November, more than a year after the High Court judgement.

12-14 November 2013 Julia's Supervisor of Midwives, Professor Paul Lewis, gives evidence and Julia provides a written statement. The new NMC Panel decides that her fitness to practise is not impaired. She is now free to practise again as a midwife without restrictions, having spent more than six years either suspended or under Conditions of Practice that severely restricted which women she could look after.

The NMC's role is to protect the public. Condemning committed and experienced midwives does not achieve this. If safety is genuinely the concern of the NMC, of the supervisory system and of senior midwives, they would facilitate rather than obstruct initiatives that provide greater safety for women and babies. For example, in one case, when an independent midwife was asked to support a woman having twins at home, an NHS Supervisor of Midwives and two local NHS midwives were able to support her. In another example, a senior midwife set up a rota of experienced midwives to work with an independent midwife to attend a woman having a breech birth at home, but the LSAMO refused to allow this. In order to ensure safety, the NMC and the supervisory structure need to align themselves with midwifery knowledge and skills. If NICE Guidelines are the main judge of a midwife's practice, this is clearly not the case.

Surely we should be supporting any midwife to set up as safe circumstances as possible for every woman,[8] whatever decisions the woman makes, rather than wasting public time and money by hounding the very midwives who attempt to do this.

Nadine Edwards

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What is FGM?

Siobán O'Brien Green highlights the serious issues surrounding female genital mutilation

Female genital mutilation (FGM) is the partial or total removal of the external female genitalia, or any practice that purposely alters or injures the female genital organs for non-medical reasons, as defined by the World Health Organization (WHO).

The practice is internationally recognised as a form of gender-based violence and a fundamental violation of the human rights of women and girls: it subjects them to extreme health risks and may have life-threatening consequences.[1]

Evidence of FGM has been found dating back thousands of years and the practice pre-dates all world religions such as Christianity, Islam and Judaism. FGM is concentrated mainly in 29 countries located across Africa and the Middle East (see below for list of countries). It is also practised in other regions and tends to be more associated with ethnicity than with nationality. Reports from Europe and other areas of inward migration such as North America indicate that FGM may continue to be practised amongst immigrant communities. Statistical estimates from census data suggest that in England and Wales more than 65,000 women and girls have undergone FGM, whilst in the Republic of Ireland data suggest that more than 3,700 women and girls residing in Ireland are victims of the practice. Both of these figures are likely to be an underestimation of the current FGM prevalence statistics.[2] In 2013 UNICEF estimated that globally more than 125 million women and girls have undergone some form of FGM.[3]

As with many harmful traditional practices, FGM is carried out by communities to continue their heritage and sustain cultural norms and values – many believing that they are continuing a practice based on the best interests of their children. FGM often aims to control a woman's sexuality and preserve virginity until marriage, which may enhance a girl's marriageability, and is frequently seen as a rite of passage and a way to conform to cultural standards of femininity and beauty. FGM is most often performed on girls between five and 14 years old, but this can vary with ethnicity, ranging from when a baby girl is a few days old to when a girl or woman is pregnant with her first child. FGM is a manifestation of long-held and continuing gender inequalities in a society and is a deeply traumatic and harmful form of gender-based violence.[4] However, it should be noted that FGM is usually carried out by women (sometimes traditional birth attendants) who receive both status and income by performing FGM on girls.

Countries where FGM is concentrated[3]

Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Iraq, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen.

FGM has many harmful consequences, both short and long term, including but not limited to: death, haemorrhage, tetanus, pelvic inflammatory disease, scarring, dysmenorrhoea (painful periods), dyspareunia (painful intercourse) and increased possibility of HIV and Hepatitis transmission. FGM is also associated with increased risk of developing psychological problems such as PTSD, anxiety and depression.[2] A major WHO study in 28 obstetric centres in six African countries found an increased risk of complications in women with FGM I, II and III, (see definitions on page 15) such as: caesarean section, postpartum haemorrhage, extended maternal hospital stay, infant resuscitation, stillbirth or early neonatal death and low birth weight. FGM was estimated to lead to an extra one to two perinatal deaths per 100 births in the study.[5]

Working with women who have undergone FGM

For midwives, and other healthcare professionals, knowledge is imperative to provide the best possible care for women who have undergone FGM and to respond to women in a culturally competent manner. Any woman who is born in, or has a parent from, a country or region that practises FGM may have undergone FGM. All discussions of FGM must be sensitive, woman-centred and mindful of cultural issues, privacy and possible language difficulties. A professional interpreter may be required to facilitate communication and understanding. It is not appropriate to use a family member, such as a husband or child, as an interpreter. Women may not be familiar with the term FGM or may find it insulting, and may, instead, refer to being cut, closed or circumcised. It is important to question and respond in a professional, caring and sensitive way to develop a trusting and respectful relationship. Any medical interaction or appointment with a woman who has been subjected to FGM provides the opportunity for recognition, appropriate referral, care and support and possibly preventative work, all of which are vital to ensure that the practice of FGM is not perpetuated. A list of hospitals and clinics in the UK offering specialist FGM services is available on the Forward UK website. These clinics can be contacted for advice and referrals. Further information on treatment and child protection is available on the FGM National Clinical Group website.

Women may present with symptoms that they do not associate with FGM or in some cases women may not be aware that they have undergone FGM, if it occurred when they were a baby. However, early identification in pregnancy of a woman who has undergone FGM is essential to plan care for her pregnancy, birth, postnatal period and to prevent re-suturing (re-infibulation of Type III FGM) requests after birth. Prompt assessment and

WHO Typology of FGM[1]

Type I – Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II – Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III – Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV – All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

examination is especially needed when a woman is pregnant, as FGM may have left scar tissue, adhesions and in many cases a direct barrier to vaginal delivery. It is also key to discuss FGM prior to the birth as this is often a period of heightened fear and anxiety for women with FGM and a good rapport with midwives can assist greatly in alleviating concerns. Information should also be offered to the woman's husband/partner including the health repercussions of FGM, support available and legislation where applicable. FGM is considered a form of child abuse and it should be dealt with through existing policies for child protection. Referrals to Social Workers may be required, especially if a woman with FGM gives birth to a girl.[2] Working with women who have undergone FGM is often traumatic and upsetting for midwives and healthcare professionals. Seek advice, assistance and support in relation to self-care if required whilst being mindful of women's privacy. Contact any of the specialist FGM services listed on the Forward UK website for professional support and more information.

Legislation and prevention

Legislation is one apparatus in the movement for global eradication of FGM and it can encourage and support communities to abandon the practice. However, legislation must work along with community empowerment and gender equality mechanisms and efforts to eliminate violence against women to achieve long-term, sustainable change. Good practices in combatting FGM tend to be collaborative, partnership based, involve members of FGM practicing communities (including faith leaders, men and boys), be inter and multi-disciplinary and receive ongoing financial and government support. Legislation criminalising FGM exists in the United Kingdom and the Republic of Ireland, as well as in many other European and African countries. Many recent legislative developments have included the principle of extraterritoriality, whereby it is illegal to perform FGM on a resident of a country even if the FGM takes place in a different country or while a girl is on holiday.[4] Prosecution in cases of FGM is of course desirable to ensure that FGM is taken seriously by police, courts, legislative systems and processes, but ultimately it represents a failure on the part of child protection mechanisms, frameworks and structures. Overall eradication of the practice, while sensitively caring for women who have undergone FGM and protecting girls at risk of FGM, must be the long-term vision and inform all policy and work related to FGM.

Conclusion

FGM is a serious global challenge to women's health, human rights and safe birth and is a grave form of gender-based violence. While today FGM is concentrated in 29 countries, mostly in Africa, both Europe and North America have had a history of responding to women's mental illness and what was considered unacceptable or overly sexualised behaviour by preforming clitoridectomies.[6] Efforts to encourage community abandonment of this harmful traditional practice are underway through legislative and community and female empowerment approaches. Often this can involve finding alternative employment for circumcisers, focusing on the human rights aspects that FGM denies for women (such as bodily integrity, health and life) and mobilising men as fathers and future husbands to speak out against the tradition of FGM in their community. Solely emphasising the harmful health effects of FGM may have a reverse impact by promoting the medicalisation of FGM, a practice that UNICEF, WHO and the International Confederation of Midwives (ICM) strongly reject.[3] Midwives play a crucial role in effective care and support of women who have undergone FGM and also can contribute to halting the inter-generational continuation of this harmful traditional practice. Everyone has a role to play as a vocal, informed champion for change towards the eradication of FGM globally.

Siobán O'Brien Green

Siobán holds a Master of Social Science (Social Policy) and a BA in Social Policy and History of Art. She is currently responsible for policy and research at Comhlámh, the Irish association of development volunteers and workers. Siobán also teaches in the School of Applied Social Science at University College Dublin. She has researched, published and presented on FGM and gender-based violence in Ireland and Europe and is a co-author of Ireland's first handbook for healthcare professionals on FGM. Contact her on sioban.obriengreen@ucd.ie

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Master

Hazel Katherine Larkin explores the power of terminology

'When I use a word,' Humpty Dumpty said, in a rather scornful tone, 'it means just what I choose it to mean, neither more nor less.'

'The question is,' said Alice, 'whether you can make words mean so many different things.'

'The question is,' said Humpty Dumpty, 'which is to be master – that's all.'

Through the Looking Glass, by Lewis Carroll

This started as a frustrated rant. As a proud Irishwoman, I could not understand why the Chief Executive Officers (CEO) of Dublin maternity hospitals – and only Dublin maternity hospitals – insist on being called 'Master'. It grated on my feminist sensibilities and I took every opportunity I could to introduce the topic into conversation, telling people I felt such a language choice was thoughtlessly insensitive at best and outrageously patriarchal at worst. I decided to conduct a more academic investigation of my own horror at the use of the term and investigate whether the aversion to the term was just my own – or if it was shared by others.

The Patriarchy

Crucial to this discussion is the notion of the patriarchy. As feminists of whatever school or wave or allegiance, we all refer to 'the patriarchy' without, perhaps, pausing to think what we mean by that phrase. So, if you'll indulge me for a moment, I'm going to share with you what I mean when I refer to the patriarchy.

Patriarchy is characterised by current and historic unequal power relations between women and men whereby women are systematically disadvantaged and oppressed. Male violence against women is also a key feature of patriarchy.

Whether at home or in the medicalised, industrialised setting of hospital, pregnancy and birth take place in a social context.[1] Since men started to nudge their way into childbirth in the 1700s, and then, essentially, 'took over' the area a century later,[2] the terminology applied to this most feminine of events has become more technical, more scientific, more patriarchal.

As Jabr tells us *'Colonizers typically have imposed their language on the peoples they colonized, forbidding natives to speak their mother tongues.'*[3] It's not too much of a stretch to see men as colonisers of birth. So, when men first decided that childbirth was to become a science, they gave much thought to what exactly they should call their creation. Given that the naming of things is a realm of male preserve – even our most private of personal parts are named for their relationships to men (the word 'vagina' means 'sheath', implying a sheath for a penis) – it shouldn't come as any surprise, that the various alternatives considered included 'male midwife', 'midman' and even(and I find this one hard to pronounce,never mind stomach!) 'androboethogynist'.[4] I am reliably informed that that word means 'man helper of women'.[5]

These terms, however, were rejected for appearing too 'clumsy' or too reminiscent of the female title. That is to say, they were too un-scientific sounding for this new branch of medicine. In the mid-1800s, a British doctor presented us with the word 'obstetrician'. This word is from Latin and means 'to stand before'. Now, if we contrast the word 'obstetrician' – meaning to stand before – with the word 'midwife' which is Middle-German and means 'with woman', the latter is far more comfortable, less judgmental, more wholesome. Personally, in labour, I'd rather have someone 'with' me than 'before' me.

Master

To add insult to injury, however, Irishwomen have had to contend, not just with obstetricians, but with 'Masters'. This term dates from when the first maternity or 'lying-in' hospital in Ireland opened its doors in 1745. At that time, physicians actually despised midwifery (some would say little has changed), to the extent that Fellows of the Royal College of Physicians in Ireland were penalised if they practised midwifery.

The term 'Master' came about because of a financial consideration on the part of Bartholomew Mosse, who opened the Rotunda in 1745. He was advised that if awarded a Royal Charter, the hospital would become a national institution and qualify for government funding. The Charter was awarded and it provided for the establishment of a Board of Governors. It also instituted the Mastership system whereby a Master was appointed.

When the Coombe Maternity Hospital opened in 1826, it also was given a Royal Charter and a 'Master', and the National Maternity Hospital in Holles Street – which opened in 1894 – continued the tradition of calling its CEO 'Master'.

It is nearly 270 years since the first of these hospitals opened and while they all changed their names from 'lying-in' to 'maternity' or 'mother and infant' hospitals, none of them has seen fit to change the title of their CEOs from 'Master' to anything else.

Master – Why Does it Matter?

Of course, you could just say that the title a person holds is irrelevant: what matters is the job they do and the competence with which they do it. But I would argue that language is potent, that the title one assumes – whether one chooses it or merely chooses not to change it – is loaded with meaning.

So what does the word 'Master' mean? Much as I was loathe to quote the dictionary in this article, it would be remiss of me not to do so. My copy of the Oxford English Dictionary tells me that the word 'Master' means, first and foremost, *'A man in a position of authority, control or ownership.'* Secondary and tertiary meanings for the word are *'a person who is skilled in a particular art or activity'* and *'the head of a college or school'*, respectively. None of those is particularly warm and cuddly, is it?

The Australian feminist and academic Dale Spender puts it succinctly in her book Man Made Language[6] when she asserts that those who have the power to name the world are in a position to influence reality. The powers of patriarchy control the language and, consequently, women's experiences. So by continuing to use the term 'Master', those who hold the office of CEO in Irish maternity hospitals are perpetuating a patriarchal hold over – and interpretation of – women's birthing experiences. As Margaret Burke puts it, Irish women are the *'survivor[s] of systemic patriarchal subjugation.'*[7]

Challenging The Master Herself

In January of 2012, for the first time ever, a woman was appointed head of a maternity hospital in Ireland. I was cautiously excited when I heard this news. I wasn't naive enough to expect that just because the new CEO of Holles Street (the National Maternity Hospital) was female, the practice there would instantly become more woman-and-child friendly. I know that women who are trained as doctors are trained in the existing patriarchal model and, as such, are taught to believe that the medical model is the one that best serves all women. But I did hope that a woman would reject the title 'Master' and come up with a new one for herself. I hoped that a woman would bring some real change, starting with the language she used to describe herself and her position. Alas, it was not to be. Rhona Mahony kept the title 'Master', as did her friend and colleague Sharon Sheehan when she took up the position of CEO at the Coombe.

In March of last year, I met Rhona Mahony at a function for women in the media. She gave an excellent talk – coming across as human, humble and approachable. I genuinely felt that she wants what is best for every woman and every baby who crosses the threshold of 'her' hospital – which is why I felt that her dogged refusal to relinquish the title of 'Master' in favour of something less male and harsh was incongruous. I asked her why she insisted on calling herself 'Master'.

'It's the title that goes with the role,' she told me. *'It's historical. Since Holles Street opened its doors, the Master has always been called the Master.'*

I persisted and was told that, while 'Master' sounded male, the alternative – mistress – had worse connotations. I suggested that perhaps something entirely different might be appropriate. That, given we now had a woman CEO of an Irish maternity hospital – something exciting and unprecedented – we could expect radical change and embrace it. No, I was told quite firmly. It is a tradition associated with Holles Street since the hospital first opened its doors. But, I argued, just because something is a custom doesn't mean it is right. People can benefit from having customs examined and either kept, if they are seen as useful, or rejected, if they are seen to have outlived their usefulness.

The new CEO told me that she does exactly the same job as her male predecessors and will, therefore, retain exactly the same title. She is, Rhona Mahony said, more than 'just' a CEO. *'I'm still a practicing gynaecologist and obstetrician,'* she informed me. *'I still have patients. I still deliver babies.'*

This turn of phrase caused me to grit my teeth nearly as much as the word 'Master'. I dislike pregnant and birthing women being referred to as 'patients'. It serves to perpetuate the myth that pregnancy is a disease and childbirth is an illness. Also, as far as I am aware, mothers deliver babies, not doctors, not midwives, not obstetricians and definitely not 'Masters'.

'Master' is a term of affection

But I was just fighting one battle that day, so I persevered, feeling that the 'Master' issue was important enough to warrant it. I quoted Ina May Gaskin, whom I'd heard speaking at the Home Birth Association Conference in 2012, and who said *'Only slaves have masters.'* Exasperated, Rhona Mahony told me that in Holles Street, 'Master' is a term of affection. I was stunned. I had never before heard the affectionate implications in the word. I tried to pursue the issue, but I was promptly shut down – or shut up – by the chair of the discussion. She stepped in and told me that what was important was not the title, but the person. I was aware that I was being silenced and that when we start silencing other women, we are doing patriarchy's job, but I shut up and sat down.

Afterwards, three of the other women at the talk told me that I had asked the very question they weren't brave enough to. They agreed with my position and felt ill at ease with the word being used in this context.

Survey

I designed a short survey to see what images the word 'Master' summoned up in people. I was careful not to supply any idea of what I was expecting – as I truly wanted to know what other people felt, rather than simply confirm my own bias. While not wishing to mislead, my opening statement was necessarily vague. It simply stated that I was doing a quick survey exploring how language inspires images.

Thereafter, the question *'Please tell me what words, phrases and/or images the following word inspires'* was replicated with six different words: Mum, Free, Master, Desert, Cold and Warm. The only responses I was interested in were the responses to the third word – Master.

I had 93 respondents, all of whom were anonymous and self-selecting. I reached people via a number of social networks. I deliberately didn't post a link to the survey on any of the midwifery or birth groups I'm part of because I figured they'd cop on fairly quickly to what I was up to! I wanted responses to be as 'clean' as they possibly could.

With regard to the 93 who completed the survey, there were more women than men – of whom there were just 12. I had responses from five different territories (Ireland, the UK, Austria, the US and France), with most (75) being from Ireland.

All that interested me were the responses to the word 'Master' – so they were the only responses I analysed. I took the 10 most often-occurring words and reproduced them in Figure 1.

As you can see, the image most commonly associated with the word was that of a slave.

The second most commonly-occurring image was boss, with the third being fear. Certainly, there's nothing that suggests 'affection'.

Conclusion

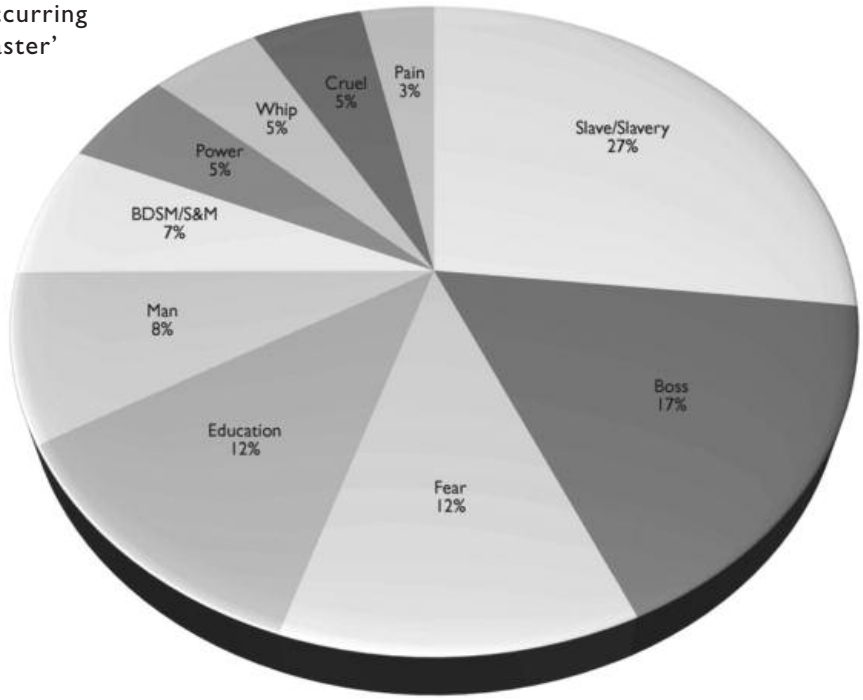
In an environment where the person in charge holds a title that most people associate with slavery, the possibility of women owning their own birthing experiences is diminished. Language *'is not merely about actions, events and situations, it is also a potent and constitutive part of those actions, events and situations.'*[8] The language sets the agenda for the interaction and women are routinely excluded from their own pregnancies and births because someone other than them is the 'Master' of the experience.

'Birth in western society has become an institutionalised act of violence against women.'[9] Having 'Masters' as CEOs of maternity hospitals (where all but 2% of babies in Ireland are born) confirms that attitude. While I accept that the title is historical, I feel that an opportunity to drag the office into the twenty-first century was lost when Rhona Mahony refused to do so. An example that springs to mind is John Kelleher. In the interests of transparency, I must declare that I know John; we worked together in television production in the mid-nineties, and I have a lot of respect for him. In 2003, he was appointed Irish Film Censor. Shortly after his appointment, John decided that a name-change for the office was in order. The post is now known as 'Director of Film Classification'. The job was essentially the same, but the perception of it is vastly different. The office-holder would still decide what was suitable viewing for those under 18; but those over 18 could decide for themselves. There would be no more 'censorship' – there would be nothing paternalistic or patriarchal about the office from 2003 on.

It worked. John Kelleher successfully changed the name of the office, and with it the perception of the office. He gave several media interviews around the issue and the change was smooth, done with ease and accepted by the general public.

I do believe that, if the will were there, the name of the office of CEO of maternity hospitals could be changed just as easily. I am mindful of the late Marsden Wagner's seminal piece *Fish can't see water: The need to humanise birth*,[10] in which he points out that fish can't see the water they swim in – and in the same way, doctors and others who work within the medical model of childbirth don't actually know any better. They are not trying to be unkind to women and babies, they just don't know anything other than the method in which they were trained. The medical model of childbirth teaches its students the languages of science and power – of technology, of industrialisation, of intervention, of patients being 'allowed' to do this or that, of helpless women who need to be rescued by doctors[11] – and it teaches them well. At its best, the woman-centred, midwifery model of

Figure 1
The 10 most frequently occurring responses to the word 'Master'



childbirth teaches its students the language of love; the language of being 'with woman', of being privileged witnesses as new life bursts forth, of holding the sacred space while the labouring woman is empowered to get on with doing what it is she was designed to do.

Peace on earth begins with peace at birth, and in order to effect peace in our society, I really believe that we need to get rid of our 'Masters'. Those who hold the positions of CEO of maternity hospitals in Ireland need to learn to speak, fluently, two paradoxically different languages – the language of power and the language of love. *'Until we are able to exercise power and love together – to exercise power with love – we will never be able together to create new realities.'*[12]

Where To From Here?

I don't believe in presenting a problem without any suggestion of a solution, so I've started a petition that I hope to present to the various CEOs of the maternity hospitals in Dublin. If you feel moved to sign it, please do. www.ipetitions.com/petition/no-more-maternity-masters/

Hazel Katherine Larkin

Hazel is a mum who holds a BA (Hons) in Psychology and an MA in Sexuality Studies. She is currently researching for a PhD at the School of Nursing and Midwifery, Trinity College, Dublin.

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Perinatal pitocin

as an early ADHD biomarker: neurodevelopmental risk?

Authors

Kurth L, Haussmann R.

Journal

Journal of Attention Disorders 2011 Jul;15(5):423-31. doi: 10.1177/1087054710397800. Epub 2011 Apr 28.

AIMS comments

Administering synthetic or artificial oxytocin during childbirth may be the most common labour intervention in the world. If it is, then it is crucially important to know about any unintended harmful effects. A study published in 2011 by Kurth and Haussmann strongly suggests a link between increases in the use of pitocin (an artificial oxytocin, known as syntocinon in the UK) around the time of birth and subsequent childhood attention deficit hyperactivity disorder (ADHD). The authors looked at the birth records of 172 children aged between three and 25 and considered obstetric complications, family incidence of ADHD and gender. They found that perinatal pitocin exposure was a strong predictor of ADHD diagnosis which occurred in 67% of those children exposed to pitocin and in 35.6% of those who were not. This work was done as part of a PhD.

The sample is not representative and the proportion of ADHD in this sample is above what you might expect to come across in a general population, but the finding is so clear that further research is needed. There are already concerns about correlations between pitocin use and autism (see www.sarawickham.com/research-updates/induction-augmentation-and-autism/), as well as an increase in postnatal bleeding, so in my view we must press for more research to clarify these relationships, but in the meantime far more caution should be exercised before using this powerful drug.

Gill Boden

Safe Prevention of the Primary Cesarean Delivery

In February 2014, the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine issued a joint consensus statement, Obstetric Care Consensus Statement: Safe Prevention of the Primary Cesarean Delivery.

What the consensus says

By 2011 one in three women had caesarean sections in the US, but *'the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused.'* Evidence of potential short-term and long-term harms from the overuse of caesareans is cited, particularly for women and babies in subsequent pregnancies, due to increased placental problems.

As in the UK, wide variations in caesarean rates are documented – between states (23% to 40%) and between hospitals (7.1% to 69.9% overall, and 2.4% to 36.5% for women deemed 'low risk').

Main reasons for women having caesareans included: first baby, slow labour, concerns about fetal heart rate tracings, fetal malpresentation, twins or more and suspected large baby.

The statement looks at these and other issues, and makes recommendations for practice which could decrease the caesarean section rate. For example:

- *'Slow but progressive labor in the first stage of labor should not be an indication for cesarean delivery',* suggesting that more time should be given before deciding that interventions are needed. It is also recommended that the active phase of labour should not be diagnosed until the woman is 6cms dilated.
- *'A specific absolute maximum length of time spent in the second stage of labor beyond which all women should undergo operative delivery has not been identified.'* For healthy women and babies, the statement recommends at least two hours in second stage for women who have had a baby and three hours for women having their first babies, but that this could be longer if progress is being made, before considering interventions.
- changing the mother's position, which might resolve concerns about the baby's wellbeing if decelerations in the baby's heart rate are thought to be due to cord compression.
- advising induction of labour for medical reasons only before 41 weeks and 7 days of pregnancy. At and after this time induction is recommended in order to reduce the risk of caesarean delivery and perinatal mortality and morbidity.
- offering cervical ripening methods for induction in women with an unfavourable cervix.
- *'Suspected fetal macrosomia is not an indication for delivery and rarely is an indication for cesarean delivery.'* Thus caesareans should only be offered to women with babies over 5000g (4500g for women who have diabetes), though *'estimates of fetal weight, particularly late in gestation, are imprecise'* and ultrasound to estimate the baby's weight in the third trimester of pregnancy should be used sparingly.
- *'Perinatal outcomes for twin gestations in which the first twin is in cephalic presentation are not improved by cesarean delivery.'* It is recommended that women expecting twins, where one or both are head down, should be advised to plan vaginal births, but that skilled practitioners are needed.
- *'Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula.'*

The statement concludes by acknowledging that changing obstetric culture and practice is remarkably difficult and numbers of suggestions are made for change, including controversial tort reform.

AIMS comment

This consensus statement has been described as a *'game changer'* (www.scienceandsensibility.org/?p=7958) and would certainly be a departure from usual current practice in the US. It is important because it acknowledges both the short and long-term risks of caesarean sections for mothers and babies, and sets out the known evidence (and rates this evidence) with a view to reducing the numbers of first caesareans. Some of the main recommendations are to allow more time for labour and birth, to wait longer before diagnosing 'failed induction', to expand normality, and to retain or improve clinician training and skills (such as rotating the baby's head manually when it is posterior or to the side during the second stage of labour, offering operative vaginal deliveries as a safe alternative to caesarean section, and offering external cephalic versions to women with breech babies near or at term). It also accepts that continuous support is beneficial for women and reduces the need for interventions.

Of course, this statement remains within a medical framework, using medical language, and describes a largely medicalised philosophy and practices. A consensus for reducing the numbers of caesareans might look rather different if it were based on midwifery knowledge and informed by what we know about the physiology of birth and the benefits of continuous support from a trusted midwife. This could include, for example, taking a much more individualised approach to induction, generally avoiding arbitrary time limits (rather than just extending them), encouraging healthy women to birth in community settings, providing environments that least disturb the woman in labour and encouraging women to move as they want during labour and birth, thus reducing stress and the likelihood of fetal distress which could reduce the need for the recommended medical procedure of amnioinfusion for some instances of fetal heart rate decelerations.

Nadine Edwards

Safe prevention of the primary cesarean delivery. Obstetric Care Consensus No. 1. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:693–711
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SCPHRP (Scottish Collaboration for Public Health Research and Policy) Public Seminar:

Exploring continuity of care in maternity and post-natal services, 27 May 2014, David Hume Tower, University of Edinburgh, UK.

The conference's purpose was to consider the *'growing evidence that continuity of care improves maternal and child care outcomes'*, and to look at the implications of this, what it means, how it can be done and how to go forward with it.

Professor Helen Cheyne, Royal College of Midwives Professor of Midwifery and Professor of Maternal and Child Health Research, Nursing, Midwifery and Allied Health Professionals Research Unit, University of Stirling, made a strong start to the conference with her address, *'Continuity of care: what is it and how can it be delivered?'* Helen described the fragmented and impersonal 'production model' of maternity care which was one of the prompts for the enquiry leading to the Winterton Report in 1992. Helen quoted from and urged all those present to re-read this crucially important report, which among other things recommended a woman-focused service within which the woman would get to know and trust the midwife looking after her during pregnancy, birth and postnatally. The Winterton Report was followed by Changing Childbirth in 1993 – again promoting continuity of care. There was a strong move towards continuity of care and hopes that this would be embedded in maternity services. Many trials of various shapes and sizes were conducted throughout the rest of the 1990s and were well evaluated. There was however no overall consensus about what continuity means (nor how to sustain it beyond the projects and trials). Helen laid out three ways of defining continuity:

- Informational continuity (all singing from the same hymn sheet)
- Management continuity (everyone offering the same care)
- Relationship continuity

She suggested that continuity is about relationship continuity, and that there is no question that this offers benefits to women and families, but that there are unique challenges to this in maternity services because of the relative unpredictability of birth. She described two possible approaches depending on the level of continuity aimed for, suggesting that team midwifery (where 'teams' are up to 15 midwives or more) works against the possibility of relationship building and continuity.

If the aim is for women to know the midwife looking after them during birth, one potential model is to have teams of 6-8 midwives, based in small geographical areas with a caseload of 40 women each per year. Each midwife works with a partner midwife and is on call for her caseload women, but both can provide cover for each other. The midwives have no other service commitments and flexible hours, thus having control of their work.

If the aim is to provide continuity for 'planned episodes of care' (antenatal and postnatal), Helen described a different model whereby the woman has a named midwife and up to three other midwives involved in her care. Midwives have a caseload of 38 women each, work with a partner midwife across all clinical areas, have flexible shifts negotiated by the team, a shared philosophy, no on-call duties and some service commitments. These midwives have some control of their workload, but less than the model above.

Helen rightly asserted that we know what continuity is, we know how to do it, we know that it works and we just need to prioritise it and do it!

Eileen Scott, Public Health Adviser, Evidence for Action Team, Public Health Sciences Directorate, NHS Health Scotland, spoke next about *'Continuity of care: The evidence.'*

The focus of Eileen's talk was on addressing inequalities (social risks), as much as physical risks during childbearing. Her premise was that health inequalities are both systematic and avoidable: those with least resources and power have poorest health outcomes and social risks are often compounded by circumstances outside the control of those suffering them, as demonstrated by the Confidential Enquiries into maternal deaths for example.

Social factors included:

- poverty
- mental health challenges
- domestic abuse
- recent migration/language challenges
- substance misuse
- aged under 20

Often these factors go together, so that a woman is likely to suffer several disadvantages. Of course, as Eileen acknowledged, the underlying causes are rooted in poverty, which is systematically constructed and maintained at societal level. However, in terms of maternity services, continuity of care can make a positive contribution, as research by NICE (National Institute for Health and Care Excellence), the NPEU (National Perinatal Epidemiology Unit) and SEBCHU (Scottish Evidence Based Child Health Unit) over the last decade confirms.

Eileen highlighted the problem women have accessing services and discussed 'cognitive' as well as physical access – for example, women suffering from domestic abuse do not tend to book late, but tend not to disclose their circumstances. This 'cognitive access' is more difficult to look at and measure in a quantitative focused arena, but is based on relationships. Research shows that women often feel judged and uncomfortable and that staff can be judgemental, lack knowledge of support services and do not understand the issues women face. This is exacerbated by fragmented care. Research also shows very specific benefits of continuity of care, and the increased communication that arises from this, for different groups of women. For example, women suffering from domestic abuse are more likely to talk about this, those suffering from substance misuse are more likely to maintain contact with services, recent migrant women are more likely to access the services they need and remain in contact with services, and for women under the age of 20, continuity of care is one of the only factors that helps women stay in contact with services. As these disadvantages cannot be known beforehand, every woman should have continuity – at least initially.

The final speaker was **Dr Mary Ross-Davie**, Education Projects Manager, Midwifery and Reproductive Health, NHS Education for Scotland, on *'Where next for continuity of carer in Scottish maternity and postnatal care.'* Mary carried out a small survey of the 14 Heads of Midwifery in Scotland and of the 10 who replied, 9 said that continuity was a priority for them – though the main focus has been on improving continuity during pregnancy. Mary suggested that the Cochrane Review on continuity is unequivocal and that we need to shift the continuity focus from care to carer. She also suggested looking at past and current initiatives in Scotland and other parts of the world that have provided or provide continuity and that work for women and midwives, such as the small birth centres in the west of Scotland, a new scheme in Lothian, the Glasgow home birth service provided by two midwives with support from community midwives, the caseloading model in Windsor NHS where the home birth rate is 35%, the One to One Midwives in the Wirral and elsewhere, and the community-based caseloading model in New Zealand.

Mary identified some of the barriers for midwives, which include caseloads being too high (such as in the Netherlands and elsewhere), many midwives working part-time and the perception that it is not feasible. For example, although the One to One scheme initiated by Lesley Page in West London was well evaluated, it did not spread – partly because imposed financial constraints led to it being seen as a luxury for well-off women and partly because midwives looking at it from the outside saw the midwives providing it as 'heroic' and going 'beyond the call of duty' in ways they felt would be unmanageable for them. Mary suggested promoting the benefits of continuity, such as regaining the status and role midwives once had, working in local catchment areas, basing care in the community and finding 'champions'.

Editor's note: Contrary to popular belief, qualitative research shows repeatedly that caseloading midwives are able to sustain this if they are well supported. It also shows that they enjoy working with women they know, and feel that they can provide a safer and better service to the women and families in their care.

Mary concluded by calling for more care in the community and integrating health and social care, with midwives co-located with other staff. She laid out the questions and challenges: how to upscale sustainably, such as starting small/local or having a national strategy, making small shifts in ante and postnatal care or radically restructuring. She also rightly stressed that midwives need to feel that there are benefits for them, that they are well resourced and supported, that there is flexibility in the workforce, that they are confident in community settings and that they are enabled to manage their own time with adequate time off (a particular challenge for those in management who find it difficult to relinquish control). She also suggested that women need to demand it and that a tipping point needs to be reached, where continuity is seen as the 'new normality'.

Lively debate ensued! This focused on the integration of services, how to work with the voluntary sector, working well with health visitors and other services, increasing the numbers of midwives, looking at continuity in the context of long-term wellbeing and cost effectiveness. Helen Cheyne discussed her report Having a Baby in Scotland 2013: Women's Experiences of Maternity Care (www.nmahp-ru.ac.uk/files/2014/01/Maternity-survey-final-report-2014.pdf), which will be able to link women's experiences to outcomes, providing more evidence about the benefits of continuity.

As any reader of a certain age can imagine, this was both a frustrating and heartening conference. It was frustrating to see yet again the limits of our collective memory of even very recent history – all those midwives who worked so hard to promote, provide and evaluate continuity through endless pilot studies and schemes in the 1980s and 1990s must want to throw in the towel – and Helen Cheyne emphasised the need to avoid reinventing the wheel. It was heartening to hear relationship continuity throughout pregnancy, birth and the postnatal period moving from what could only be described as a 'dirty word' in Scotland to being talked about positively. Both Helen and Mary were crystal clear – we know what it is, we know how to provide it, the evidence supports it, we need to get on and do it! This would be a very welcome sea change – and in my humble opinion, in answer to Mary's questions, we need to have a radical restructuring at national level. Scotland is small and cohesive enough to do this and we have tried the small scale and tried the 'small steps' approach. Neither work at embedding continuity in maternity services and all too often these small schemes depend on key individuals and fold when the individuals move on, even when they have been well evaluated.

Nadine Edwards

Marsden Grigg Wagner MD

23 February 1930 – 27 April 2014

Marsden Wagner, who died at the age of 84, will be known to thousands of childbirth activists and midwives as a champion of quality midwifery care. He trained as a perinatologist and a perinatal epidemiologist and became the World Health Organisation (WHO) Regional Officer for Europe. He was responsible for organising three international conferences on appropriate technology for birth, and insisted that there was consumer representation at each one of them. I was invited to two of those conferences to represent consumers in Europe (there were consumer representatives from North and South America too).

At the WHO International Conference on Appropriate Technology for Birth, Marsden suggested I chaired a session with President of the International Federation of Gynecology and Obstetrics, Professor Roberto Caldeyro-Barcia, who then told me that he wanted me to open the session and introduce the speakers as I would be far better at keeping the medics to time.

Marsden was an outspoken critic of the medicalisation of childbirth and a fierce defender of midwives. He travelled the world giving evidence on behalf of those midwives who were, and still are, subjected to the international witch-hunt, and who were providing skilled, respectful care to women. He also pointed out that often it was when a baby died that doctors and others would pounce, assuming poor care – standards that are not applied when a doctor is involved in a baby's (or even a mother's) death in hospital.

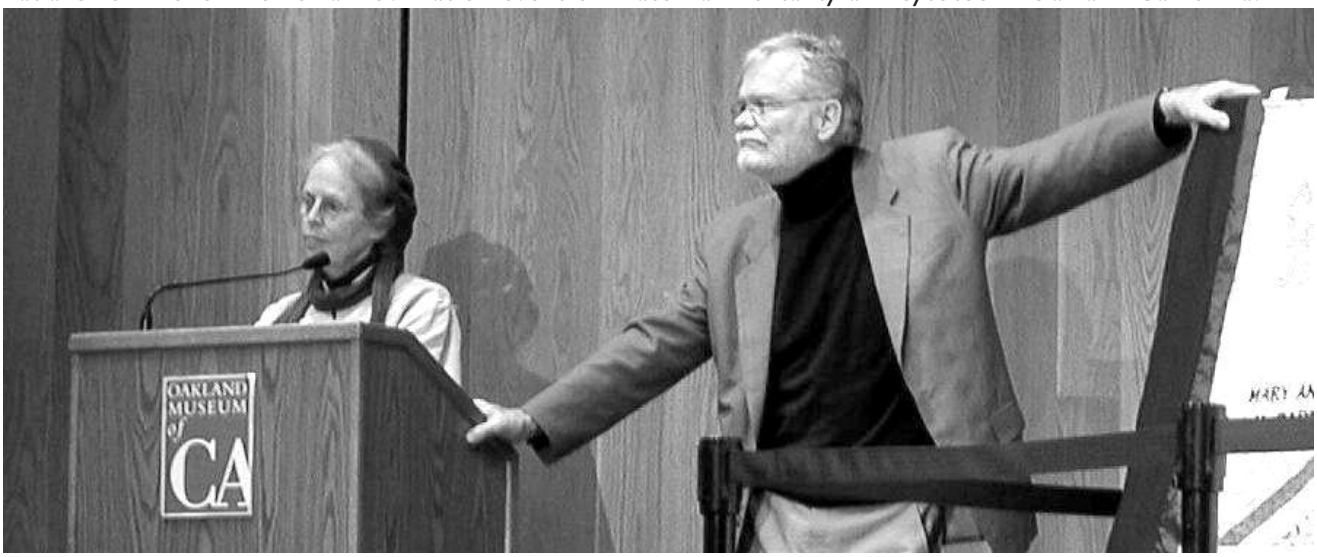
Marsden was a wonderful supporter of AIMS and always responded immediately to any appeal with words of wisdom and suggestions. His championing of normal birth began when he was invited to observe a homebirth and he then realised the power that women have to birth and how the medicalisation of birth has diminished that power and perverted normality.

He was a witty and sharp observer of the hypocrisy of many of his medical colleagues; and took great delight at conferences in finding out the statistics for various interventions and pointing out to the assembled audience how those interventions could not be justified – they hated it. He often commented that the doctors wanted to kill him. His warmth and willingness to comment and leap into the fray will be greatly missed by everyone who knew and worked with him.

His book Pursuing the Birth Machine and the articles Fish can't see water: the need to humanize birth in Australia (www.birthinternational.com/articles/birth/18-fish-cant-see-water) and Bad Habits – a poor basis for medical policy (www.aims.org.uk/?Journal/Vol11No4/ badHabits.htm) should be read by everyone involved with childbirth.

Beverley A Lawrence Beech

Marsden Wagner with Ina May Gaskin speaking on preventable maternal deaths at the 2004 Tatia Oden French Memorial Foundation event on maternal mortality and cytotec in Oakland California.



Photograph by kind permission of Maddy Oden, Chair of the Tatia Oden French Memorial Foundation www.tatia.org. Original image at www.sciencebasedbirth.com/Maternal%20Mortality_04/index_page_MaternalDeaths.htm

A zumba-induced baby

Virginia Hatton shares her story of being pregnant for 40 weeks and 18 days

Women in my family tend to be pregnant at least 42 weeks, so I always knew my baby would be 'late'. I disagreed with the due date predicted by my three-month scan and thought my actual 'forty-week mark' was about 12 days later. I wrote to the Head of Midwifery to say that I expected to be supported in a homebirth even if I went past 42 weeks. I was told I could only have a homebirth up to 42 weeks. However, thanks to AIMS, I knew it was my right to birth at home and I knew that my baby would come when he was ready.

I declined a 'stretch and sweep' and induction after I was a week 'overdue'. Since I had declined induction I was referred to a consultant, who was surprisingly supportive and said that 20 years ago I wouldn't have been induced, so it was my decision. The hospital offered additional monitoring, which I declined since I didn't believe I was that overdue. I was constantly aware of every kick in the womb, which was more reassuring to me than any scan could be.

When I was 17 days 'overdue', my doula invited me to a zumba class. The instructor danced with me saying, 'Let's get that baby out tonight! Show off your beautiful bump!'

I knew that my baby would come when he was ready

The next morning 18 days 'overdue', I had a bloody show and very mild contractions throughout the day. By 5:30pm the contractions were every two to three minutes and we asked our doula to come over. At about 8:30pm, I knew it was time to call the midwives after I had a good cry and threw up. I'd been keeping the pool as my incentive for pain relief and looked forward to getting in. However, once I was in, it didn't feel as good as the TENS machine and I had to check the thermometer to confirm it was actually warm.

When the first midwife arrived our doula asked her to read our birth plan before entering the birth space. I was in the pool for about 45 minutes and then got out after the midwives said our baby's heart beat was getting high. I kneeled facing our couch with husband holding my hands. I was there for about 35 minutes when the midwives announced the head was out. I chose not to have vaginal examinations so I wouldn't know how far (or not far) along I was and to have no directed pushing. I felt no distinction between contractions and pushing, so had pushed him out without even realising it! Our baby was born at 10:25 with his water sac unbroken. The cord was short so the midwife cut it once it stopped pulsating and I was able to bring him up to my breasts and look into those newborn eyes.

My husband and I were in such shock that the labour was over so quickly and the baby was here, that we let our guard down a bit and left things to the midwives. Everything became very rushed as I focused on delivering the placenta, which took about an hour.

After the placenta came out, I was examined by the midwives who said I had a minor tear and we would need to transfer to the hospital to do the stitches. After a physiological birth and third stage it was disappointing to go into the hospital. However, it was better than being stitched up by an anxious midwife who did not want to do stitches at home. Finally around 2:30am we went to sleep in our own bed, looking forward to sharing the long-awaited news when morning came.

Virginia Hatton

Reviews

Dynamic positions in birth: a fresh look at how women's bodies work in labour

By Margaret Jowitt
Pinter and Martin Ltd, Great Britain, 2014
Publisher's recommended price £12.99
ISBN: 978-1780661155

One of the main paradoxes of birth in many high-income countries is that everyone knows that upright is better and all the clinical guidelines recommend encouraging women to adopt upright positions. But most women in the UK will give birth in an obstetric unit having watched the television programme One Born Every Minute and will find themselves on a bed. Margaret Jowitt reports that the National Maternity Survey for England for 2013 (Care Quality Commission 2013) showed that while 23% of first-time mothers had an assisted vaginal delivery, which requires being delivered with legs in stirrups, as many as 48% of first time mothers report giving birth in this lithotomy position, implying that half the spontaneous births were conducted in the lithotomy position and most of the rest occurred on the bed. 19% of spontaneous births in all women took place with the mother's legs in stirrups while 85% of women giving birth vaginally did so in a bed and 8% gave birth in a birthing pool.

In answer to the question about why women get on the bed, Margaret Jowitt suggests that the dominant presence of a bed in a labour room is the first medical intervention (though one could argue that several other interventions are likely to have occurred before a woman gets onto a bed). She asks the reader to imagine sitting on the floor in consultation with their GP at the GP surgery to understand why women find it hard to resist getting onto a bed. (It also occurs to me that in a hospital room without a pool it may imply a small degree of privacy.) She also talks of the concept of 'protective steering', where women are persuaded to conform to hospital culture with its different priorities.

I enjoyed reading this collection of thoughts, history, present practice and recommendations about positions for labouring and giving birth.

After a short history of birth furniture through the ages, complete with charming illustrations dating from ancient times, Margaret Jowitt goes on to discuss the research evidence on maternal positions and describes the 'choreography of birth', showing how the common obstetric view understates the role of an active mother whose movements interact with those of the baby and play an important part in contributing to the optimum positioning of the baby. She gives her own suggestions about a possible birthing chair and concludes that women need education about their bodies, the physical and emotional support of a midwife and the right type of

birth equipment to find for themselves the positions that will reduce their pain and let their bodies work efficiently and effectively. She argues that women may find these conditions in a birth centre, but she doesn't elaborate a great deal on this as hospitals are where most women give birth, with many being attended by doctors (40% – up from 24% in 1990) and so this is where change needs to happen.

Gill Boden

Ghostbelly: a memoir

By Elizabeth Heineman
Feminist Press, New York, 2014
Publisher's recommended price £12.99
ISBN: 978-1558618442

Now that the topic of loss in childbearing has been well and truly opened up, it seems to be addressed in one of two ways. First are the saccharine, slightly patronising and purportedly reassuring materials. Their message is one of 'This is most unlikely to happen to you, but if it does – you'll get over it.' Second are the factual, research-based, more scholarly materials, whose message is 'This is most unlikely to happen, but if it does – this is what services are available.' Elizabeth (Lisa) Heineman's book falls into neither of these camps. Hers is a fierce, feisty, no punches pulled personal account of a baby being stillborn in the USA. The message underpinning her book is 'This is what happened to me and my much-wanted baby. It was hell and I had to work bloody hard to survive the experience.'

The ferocity of Lisa's writing is thrown into even sharper relief by the rib-tickling humour that she brings to otherwise heart-rending situations. One of these incidents is the encounter with an official who haplessly endeavours to restrict her contact with her stillborn baby to thirty minutes (pages 22-3).

Thus, the mercilessness of Lisa's message is not assuaged but actually aggravated by her humour. This means that my task as a reader was not an easy one. Reading at length about her convoluted personal and

family relationships led me to question 'Why is all this detail of unlikely liaisons necessary?'' The answer eventually emerges in the form of needing to understand the context of the loss, in order to approach its meaning to all who are affected by the baby being stillborn.

I also found that Lisa's gradually emerging decision to give birth at home was a challenge to me as a reader. Beginning as carrying an aura of fatefulness, the realisation eventually dawns that the birth constitutes a sword of Damocles hanging over Lisa, her partner and her baby. Her misgivings about her homebirth decision are revisited regularly and often throughout the book and seem to linger, suspended in their unresolved state.

In the same way as the homebirth decision seems to be presented as an accident waiting to happen, Lisa's plans for another pregnancy seem doomed. Just as a child peeks through her fingers at a disturbing programme or film, I found myself torn between cutting my losses and continuing to read.

This is quite unquestionably a book that needed to be written. At the same time as there seems to be an element of catharsis for Lisa, its publication fills a gaping hole in the literature on childbearing loss. Who should be reading it and when, though, are entirely different matters.

Rosemary Mander

Nutrition in pregnancy and childbirth: food for thought

Edited by Lorna Davies and Ruth Deary
Routledge, New York, 2014
Publisher's recommended price £24.99
ISBN: 978-0-415-53606-6

Although this is a reference book aimed at health professionals working in midwifery or public health, I would recommend it to women with an interest in how pregnant women eat and how that affects their babies and, importantly, themselves. When women are pregnant they are generally highly sensitive to what they will eat, drink, smoke – and often attuned to pressure from others. Sadly, advice to women from health professionals has been too often 'what not to eat', an unhelpful, often not well-evidenced, risk-based approach, and the response from a woman's immediate circle isn't always the positive, nourishing help that we might appreciate.

Part one, Healthy Eating and Nutrition in Childbirth, details current knowledge on nutritional needs in pregnancy succinctly and helpfully. Unfortunately, current knowledge may not be very adequate: for example, the current advice on folate suggests that *'it would be difficult for women to receive all of the folate that they need in order to achieve suitable levels of folate during pregnancy; therefore supplementation with the synthetic folic acid is recommended to women, ideally before they conceive'*. This may well be the case but 40% of pregnancies are unplanned in the UK, and although voluntary fortification of food stuffs is allowed, the recommended dosage in the UK is half of that recommended in New Zealand, for example. It is tempting to conclude that we simply don't know enough to advise knowledgeably, and that research in this area is not attractive enough financially to improve our knowledge, so midwives and mothers are having to rely on incomplete information. Anne Mullen and her colleagues summarise the state of knowledge on macro- and micro-nutrients, in a useful way, pointing out that in New Zealand a third of women are thought to be deficient in vitamin D, iodine deficiencies are common and it's thought that as many as 62% of pregnant vegetarian mothers, who are often young, suffer from a lack of vitamin B12.

Similarly Victoria Hall Moran points out in her chapter on nutritional needs for lactation that advice on alcohol intake during breastfeeding is vague. This is because there is little evidence for any outcomes at the low levels that most women will want to know about. She also points out that very little is known about birth spacing, breastfeeding and nutritional needs.

Part 2 looks at context and cultural issues: for example, what constitutes food in different cultural settings; the impact of breastfeeding on children's interest in a wider variety of tastes; caring for the significant number of women with eating disorders; vegetarian and vegan pregnancies; and working with young pregnant women. All of these issues are interesting and useful to women and midwives.

Obesity is an issue causing great difficulty for midwives and mothers. This book bravely asserts that there are structural causes, larger social patterns that shape the nutritional status of individual women, and factors far beyond their own food choices. Ruth Deery acknowledges a lack of knowledge among midwives and health professionals of the social, psychological and economic effects that influence obesity as well as personal wellbeing. Midwives must help women as individuals without 'victim blaming', via 'the midwifery stance of being with the woman', and respectfully listen. When asking potentially intrusive questions about a genuine concern, 'looking straight in the eye' will help women to be able to interpret the questions as supportive rather than policing. Dieticians Brady, Aphramor and Gingras recognise that nutritional advice given by midwives can be inconsistent and prescriptive. They expound a heartening alternative approach, the Health at Every Size perspective, which is respectful of and compassionate towards all bodies of any size.

Finally, Gill Rapley's chapter on baby-led weaning is something I would like everyone to read. She concludes that research strongly suggests that denying the very young the opportunity to make feeding choices has the potential to lead to serious consequences and that health professionals need to be wary of interfering in matters about which babies probably do know best.

There is much in this book that needs to be explored as we begin to recognise again the importance of 'proper' food for the long-term health of humanity.

Gill Boden

Letters

Thank you MAM

I would like to submit feedback based on my experience of the MAM (My Airedale Midwife) care service.

I was offered antenatal care through the MAM scheme as I chose to have a homebirth with my second pregnancy.

I was assigned one-to-one midwife Caroline Allan who attended my antenatal appointments in the comfort of my home. She was contactable throughout my pregnancy and, all importantly, was available to attend the birth.

She was supportive and respectful of my choices throughout pregnancy and was at my side providing the calm reassurance I needed to help me give birth the way I wanted.

I cannot commend these wonderful midwives highly enough. They are delivering an invaluable service to women and their families with a genuine care and understanding.

I feel extremely fortunate to have had access to this service. The importance of a familiar, caring, and experienced midwife attending a labouring woman can not be underestimated if society wants more positive birth experiences. Every woman should have access to a similar service.

Ruth Dixon

Where is my midwife?

I am so sad to find that I have moved to an area where there is no form of one-to-one midwifery team care.

Until recently I lived in an area where women are able to access one-to-one, independent midwife-style care and because I am now living too far away we have had to say goodbye to my wonderful and supportive midwife.

I have moved to an area where almost all women have consultant-led care, where few have homebirths and where I am now having to push for my rights to birth at home to be respected. I have a designated midwife at my GP surgery, but I don't see her if I have an appointment at the hospital for any reason and she will be only one of 13 midwives on the rota for my homebirth.

I feel that I was slightly spoiled with my previous midwife, but it is enough to show me how different the care is and how much difference it makes, to women and the whole family. We are seriously considering looking for an independent midwife to take over, but I am upset that we will have to pay a lot of money just to get the same service I had before we moved.

Every woman should have a midwife she knows and trusts, it should not be a postcode lottery.

Sophie Rylack

Ruth's baby Anya, moments after her birth

News

Why babies smell so delicious

Research has finally proven what mums have known for a long time, babies really do smell so good that they want to 'eat them up'.

Researchers at the University of Montreal collected the scent of two-day-old babies on cotton undershirts and asked a group of 30 healthy, right handed, non-smoking women to smell them while their olfactory responses were assessed via brain scans. Half of the women had never had a baby, the other half had given birth to their first baby three to six weeks before the experiment.

Previous studies of non-human mammals have established the importance of smell in mother-infant bonding, but prior to this study there was no data on chemosensory signals in human mothers.

The reserachers found that the body odour of two-day-old babies activated the brains of both the new mothers and the non- mothers, and both groups reported the same smell intensities, but in new mothers there was a greatly increased reaction in areas of the brain linked with reward and learning. The smell of a newborn triggered the same rewarding feelings as food in the new mums.

The researchers said that, *'This circuit makes us desire certain foods and causes addiction to tobacco and other drugs. Not all odors trigger this reaction. Only those associated with reward, such as food or satisfying a desire, cause this activation.'*

Our reward circuit is designed to reinforce survival behaviors such as eating, reproduction, bonding with infants and communities and activities which give feelings of emotional safety. High levels of mother-infant bonding are essential survival behavious for all mammals, and it appears that humans are programmed no differently. This is just one more piece of evidence showing that keeping mothers and babies together and supporting their bonded relationship makes a difference to everyone.

The full study is published in the journal Frontiers in Psychology: journal.frontiersin.org/Journal/10.3389/fpsyg.2013.00597/full

Publications

AIMS Journal: A quarterly publication spearheading discussions on change and development in the maternity services, and a source of information and support for parents and workers in maternity care. Back issues are available on a variety of topics, including miscarriage, labour pain, antenatal testing, caesarean safety and the normal birthing process. £3.00

Am I Allowed? by Beverley Beech: Your rights and options through pregnancy and birth. £8.00

Birth after Caesarean by Jenny Lesley: Information regarding decisions, suggestions for ways to make VBAC more likely, and where to go for support; includes real experiences of women. £8.00

Birthing Autonomy: Women's Experiences of Planning Home Births by Nadine Pilley Edwards, AIMS Vice Chair: Is home birth dangerous for women and babies? Shouldn't women decide where to have their babies? This book brings some balance to difficult arguments about home birth by focusing on women's views and their experiences of planning to birth at home. Invaluable for expectant mothers and professionals alike. £22.99

Birthing Your Baby: The Second Stage by Nadine Edwards and Beverley Beech: Physiology of second stage of labour; advantages of a more relaxed approach to birth. £5.00

Birthing Your Placenta: The Third Stage by Nadine Edwards and Sara Wickham: Fully updated (2011) evidence-based guide to birthing your placenta. £8.00

Breech Birth – What Are My Options? by Jane Evans: One of the most experienced midwives in breech birth offers advice and information for women deciding upon their options. £8.00

The Father's Home Birth Handbook by Leah Hazard: A fantastic source of evidence-based information, risks and responsibilities, and the challenges of home birth. It gives many reassuring stories from other fathers. A must for fathers-to-be or birth partners. £8.99

Home Birth – A Practical Guide (4th Edition) by Nicky Wesson: The fully revised and updated edition. It is relevant to everyone who is pregnant, even if they are not planning a home birth. £8.99

Home Grown Babies DVD: Five inspirational and heartwarming stories of childbirth covering homebirth, waterbirth, hypnobirth, pain relief in labour, vaginal birth after caesarean (VBAC), caesarean section and gestational diabetes. Essential viewing for those wanting to know more about pregnancy and birth, and the options available to them. Includes pull out information booklet. £14.00

Inducing Labour: Making Informed Decisions by Sara Wickham: Fully revised for 2014, this is an in-depth look into the options for women who are making decisions about induction of labour and how the evidence might apply to them. Situations covered include prolonged pregnancies, gestational diabetes, and where waters break before labour. It replaces Induction - Do I really need it? £8.00

Making a Complaint about Maternity Care by Beverley Lawrence Beech: The complaints system can appear to many as an impenetrable maze. For anyone thinking of making a complaint about their maternity care this guide gives information about the procedures, the pitfalls and the regulations. £3.00
pdf available for free download

Safety in Childbirth by Marjorie Tew: Updated and extended edition of the research into the safety of home and hospital birth. £5.00

Ultrasound? Unsound! by Beverley Beech and Jean Robinson: A review of ultrasound research, including AIMS' concerns over its expanding routine use in pregnancy. £5.00

Vitamin K and the Newborn by Sara Wickham: A thoughtful and fully referenced exploration of the issues surrounding the practice of giving vitamin K as a just-in-case treatment. £5.00

What's Right for Me? by Sara Wickham: Helping women to make sense of the options in maternity care. £5.00

Your Birth Rights by Pat Thomas: A practical guide to women's rights and options in pregnancy and childbirth. £11.50

A Charter for Ethical Research in Maternity Care: Written by AIMS and the NCT. Professional guidelines to help women make informed decisions about participating in medical research. £1.00

AIMS Envelope Labels: Sticky labels for reusing envelopes 100 for £2.00

My Baby's Ultrasound Record: A form to be attached to your case notes as a record of your baby's exposure to ultrasound £1.00

AIMS Leaflet: available FREE from publications@aims.org.uk

10 Book Bundle £50.00
This book bundle contains 10 AIMS publications at a discounted price, useful for antenatal teachers, doulas and midwives.

- Am I Allowed?
- Birth after Caesarean
- Birthing Your Baby: The Second Stage
- Birthing Your Placenta: The Third Stage
- Breech Birth: What Are My Options?
- Inducing labour: Making Informed Decisions
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

First–Time Mothers' 7 Book Bundle £30.00
This book bundle contains 7 AIMS publications at a discounted price, an excellent gift for a newly pregnant friend or relative.

- Am I Allowed?
- Birthing Your Baby: The Second Stage
- Inducing labour: Making Informed Decisions
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

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