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International Witch Hunt

the campaign against midwifery

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contents

Cover Picture: Persecuted midwife and obstetrician Dr Agnes Geréb - see page 11

Thanks to Nadine Edwards and Beverley Lawrence Beech for Guest Editing this issue of the AIMS Journal

Invitations have recently gone out to AIMS members inviting them to join the AIMS Members Yahoo Group. If you are not already on the group and have not received an invitation, this probably means that we do not have an up-to-date email address for you. If you would like to update your email address on our database, please email membership@aims.org.uk including your postcode.

Being a member of the group will not only allow you to have contact with other AIMS members and to hear what the current issues are for them, but also will allow the committee to keep you up to date with what we are doing, when and where the next meetings are planned to take place and what you may be able to do to support AIMS.

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Attacks on Midwives, Attacks on Women's Choices

Nadine Edwards, Jo Murphy-Lawless, Mavis Kirkham and Sarah Davies ask whether it is a Human Rights issue

Midwives in the UK today are facing immense pressures. This article will argue that if women's rights and choices in childbirth are to be respected and strengthened, it is essential that midwives themselves are cared for and valued.

We acknowledge that if there are serious concerns about a midwife's practice, these should be examined, in order to protect the public. These cases should be judged against the Midwives Rules and the Nursing and Midwifery Council (NMC) Standards. This article, however, is concerned about the growing dominance of managerial and obstetric control and the enforcement of standard packages of care which vastly diminish midwifery practice and women's options for birth. Furthermore, it is argued that this climate has led to the isolation and scapegoating of many midwives. These midwives are often the very midwives whom women have described as exceptional for their holistic and woman-focused care,[1] and who have often been at the forefront of extending midwifery knowledge and skills.[2, 3, 4, 5, 6, 7]

Background context

Government policy promises choice, but is prepared to offer very little to women outside large consultant-led units that are understaffed and about which there are increasing safety concerns related to high levels of intervention and insufficient staffing (BBC Panorama 2011[8] and Jo Murphy-Lawless's article on page 22). These concerns include:

- the decreasing midwife to birth ratio, due to a rising birth rate, increased complexity of cases,[9] the drop-out rate amongst the more-highly educated, newly-qualified midwives,[10] and long-term vacancy rates. Heads of Midwifery confirm their concerns about recruitment and retention as a serious problem[11]
- the numbers of 'near misses' in the maternity services overall[12, 13] and the numbers of women giving birth unattended in hospital[14, 15]
- the increasing numbers of babies being born to vulnerable women[9]
- stress and heavy workloads which are implicated in the continuing shortage of midwives[10, 11]

Additionally, proposals to close freestanding Birth Centres on economic grounds (for example Corbar in Derbyshire and Jubilee in Hull) assume that women who currently use these centres can be 'absorbed' into consultant units with no increase in staff.[15] These decisions are increasing pressures on women and practising midwives who must work in and give birth in centralised maternity units, working in a system of payment by results.[16]

In this climate, rather than care being tailored to the individual woman any deviation from 'standardised' care now has to be justified.[17]

A continuation of the 'global witch-hunt'?

In 1995 Marsden Wagner, the then Director of Maternal and Child Health at the World Health Organisation (WHO), wrote an article in The Lancet entitled 'A global witch-hunt'.[18] In the article, he describes incidents where midwives, often home birth midwives, across many of the high-income countries have been investigated, harassed, prevented from practising midwifery, and even imprisoned. He comments that this often follows the death of a baby: *'One death, even if not preventable and not the result of any mistake, suddenly negates years of impeccable statistics'*. He points out that this is not what usually happens to a practitioner in a hospital setting providing medicalised care during birth. His main thesis is that those being scrutinised, victimised and penalised are providing woman-focused care that is research-based and humane, but which differs from the accepted package of the medical model.

closing down an exemplary service that the Albany Midwives had successfully provided for 12 years

Move the clock forward to 2009. In South London in the UK, midwives from the Albany Midwifery Practice attended a woman in labour at home. The birth was normal and straightforward but the baby collapsed at 25 minutes of age. The midwives immediately resuscitated the baby and transferred her to hospital, but tragically she died a few days later. Without carefully investigating the case, the Trust suspended the home birth service the following day, and the Practice's contract with the Trust was terminated a few weeks later, thus closing down an exemplary service that the Albany Midwives had successfully provided for 12 years.[7] The records of the

women who had been attended by the longest-standing Albany Midwife were trawled through; she was subjected to a lengthy supervisory investigation, and reported to the UK regulating body for midwives, the Nursing and Midwifery Council, by her Head of Midwifery. At the inquest into the case described above, the Coroner found that there was no evidence of neglect on the part of the midwives. Despite this, the midwife had to complete the previously ordered supervised practice programme of 450 hours (the maximum that can be imposed), and, at the time of writing, the NMC is continuing to investigate her referral. The Trust also maintains on its website that the Albany Practice was closed due to concerns about safety and has so far refused to remove this information, even though the internal audit on which it is based has been independently reviewed and found to be flawed.[19] A report on the Practice by CMACE has also been heavily criticised.[20, 21, 22, 23]

Between a rock and a hard place

Successive governments' policies state that midwives must support women's decisions about their maternity care and in particular must support normal birth where possible. This approach has been written into UK policy documents on the maternity services since 1993.[24, 25, 26] Thus, in order to support women who decide to avoid medicalised care, many midwives have redeveloped and extended a philosophy of midwifery care based on an extensive body of clinical and practical knowledge to support normal birth. A midwife must be able to exercise her professional autonomy and skills base in order to support each woman in her care and meet the standard laid down under Rule 6 of the current Midwives Rules and Standards, which states that the midwife:

'Must make sure the needs of the woman or baby are the primary focus of her practice'

'Should work in partnership with the woman and her family'

'Should enable the woman to make decisions about her care based on her individual needs' [27]

the woman and her baby must be the midwife's first priority and she must support the woman

The standard seems crystal clear: the woman and her baby must be the midwife's first priority and she must support the woman. In reality the tensions are potentially lethal for women, babies and midwives. As far back as the 1980s, midwives were facing these difficulties. Jan Jennings in 1980[28] and Jilly Rosser in 1988[29] were two midwives who focused on the women in their care, both of whom suffered bleeding at home. These midwives transferred the women to hospital in their own cars because they judged that ambulances were not going to reach them quickly and that the women would not receive the urgent help they needed quickly enough. What did they do wrong? They failed to call an ambulance and wait for it to arrive, rather than transferring the women in their own cars. In 1988 there were no fewer than four midwives under investigation by the UKCC's (the then regulatory body for nurses, midwives and health visitors) Professional Conduct Committee. In each case the outcomes were excellent for the mother and baby following the clinical care and decisions made by the midwives to support women in unexpected circumstances. Yet all were suspended from practice and Jilly Rosser had to take out a High Court proceeding to have her suspension overturned.[29]

Move the clock forward again to 2009. A senior hospital midwife in Paisley, near Glasgow, received a call very late one night while on duty. The call was from a distressed midwife on one of the Scottish islands. The midwife on the island was on her own and attempting to arrange a transfer for a woman who was over seven months pregnant, who had a previous caesarean section, was bleeding and having contractions. The island midwife had already contacted the hospital in Glasgow that covers the island and had been told that it was far too busy that night and was unable to help. The Air Ambulance was insisting that a midwife accompany the helicopter. A number of calls were made back and forth and finally the midwife in Paisley discussed the situation with her two senior midwifery colleagues on duty, carried out a risk assessment, contacted obstetric and paediatric colleagues and decided that they could assist with the transfer and receive the woman and her unborn baby. The midwife went with the Air Ambulance to the island and a successful transfer ensued. The mother later publicly thanked the midwife for her help.[30] The midwife however was heavily criticised by her Midwifery Manager. What did the midwife do wrong? She followed her Midwives Rules – to put the women and baby at the centre of her care – but apparently failed to follow local protocols, which were unclear, but required her to 'escalate' the problem and also contact her 'Site Controller' who was not a midwife. Presumably, the midwife (like Jilly Rosser and Jan Jennings) was concerned about the time delay for a woman in need of urgent help, and felt confident that as an autonomous practitioner, she was making a competent decision, having reviewed all the possibilities in an emergency. Common professional expectations require midwives to respond to women's needs, but organisations are primarily concerned with the organisation's needs, and only concerned with women once they are their 'patients'. As Mavis Kirkham describes in her article on page 13, this is not about woman-focused care, this is about systems-focused care. Recently, a midwife was even required by managers to do an assertiveness course in order to be able to persuade women to fit in to local maternity protocols. Yet as one midwife pointed out about a woman who did not take her advice, 'She didn't book me to bully her ... She booked [me] ... to get out of being bullied'.[31]

What is all this about?

To return to Marsden Wagner's article, he observed that *'there is no apparent slowing of the global witch-hunt'*. He predicted correctly: since the high-profile case of Jilly Rosser,[29] and the case of Jan Jennings[28] in the 1980s, there has been a steady and increasing stream of midwives reported to the NMC. The NMC states that between 2005 and 2009, 397 midwives were ordered to undertake supervised practice while 120 midwives were referred to the NMC Fitness to Practice Committee. The number of referrals increased between 2007-2008 and 2008-2009 from 29 to 44 midwives. Marsden Wagner describes this phenomenon of persecution as an attempt to exert *'control of maternity systems'*, by *'display[ing] lack of safety'*. This is very clear in the charges brought against midwives who have been reported to the NMC and their Local Supervisor of Midwives over the last few years. Safety is defined as obstetric safety, which in and of itself is not necessarily safe[32, 33, 34] and in which midwifery knowledge and skills are largely unrecognised and dismissed. As pointed out by the Department of Health, *'Safety is not an absolute concept. It is part of a greater picture encompassing all aspects of health and well being'*[24] but this is frequently ignored. Thus midwives face charges of not carrying out procedures which in fact will not add to the safety of the woman and her baby while the attentive care they do give is not seen as contributing to safety. For example, midwives have been accused of failing to monitor babies' heart rates at 15-minute intervals and after each contraction while the baby is being born, failing to carry out regular vaginal examinations, and/or failing to monitor women's temperatures.

no scientific basis for requiring midwives to carry out any of these practices routinely

There is no scientific basis for requiring midwives to carry out any of these practices routinely, and in most cases the women had strongly stated verbally and in writing that they did not wish routine care of this kind. Despite this, where these charges have been brought, most of the midwives have been found guilty of misconduct and given lengthy conditions of practice, or have been struck off the NMC register. Many of the charges against midwives providing the non-medicalised care that women requested focused largely on their record-keeping, or on charges that would not have contributed to a different outcome for the baby. To go back to the issue of temperature, for example, in one case, a midwife was charged with not recording the mother's temperature. The midwife agreed that she had not done so, because in her clinical judgement, there was no need to take the mother's temperature and thus none to record. Nevertheless, she was found guilty of the charge of not recording the temperature, and this contributed to a verdict of misconduct. Yet the standard of record-keeping under examination is better than many records often seen in hospitals. Furthermore, poor record-keeping, unless persistent, should be dealt with locally, on site. It seems extremely difficult for midwives to get this right: one midwife was told at an NMC hearing that her record-keeping was too good and therefore she could not possibly have written the notes during the woman's labour and birth – despite the woman stating that the midwife wrote up the notes during the labour and in her presence.[35]

Midwives defying rules and regulations – at their peril

We are now experiencing a very complex political environment about health care systems in general. Specifically, in relation to childbirth, this centres on containing and reducing the burden on organisations of risk related to adverse outcomes[36, 37] This is leading to increased pressures to contain and centralise practice in accordance with institutional requirements rather than individual need. One midwife told us that she recently visited the unit where she had previously worked. She observed that the midwives there are now required to sign and date a contract in women's notes which says that they will perform a vaginal examination every four hours, and listen to the baby's heartbeat every 15 minutes in first stage of labour and every five minutes in second stage of labour. A rigid adherence to guidelines and protocols has been prioritised over a response to the wishes and needs of individual women whenever and wherever those women's choices are not the same as management-defined 'right' choices.[38] This is most apparent in concerted actions against home birth practitioners, but there is also a pattern of victimisation of midwives within local NHS trusts. Thus while Independent Midwives are particularly at risk, any midwife can face:

- immediate restrictions being placed upon their practice by employers, midwifery supervisors and/or the NMC
- being suspended and subject to internal professional investigation by employers and/or supervisors, without proper safeguards or representation or with anything clear against which to measure their practice
- attacks on the credibility of their knowledge and of their professional practice
- systematic isolation, and where they are employed by the NHS, gagging clauses being imposed
- an unseemly length of time for the investigation process to take place, in which period the self-employed, suspended midwife is deprived of her livelihood and suffers further from isolation; investigations have been known to take in excess of five years since the precipitating incident
- inadequate support and representation from trade unions and other professional bodies – in the recent Glasgow case, the Royal College of Midwives representative agreed with a midwife's employer that her actions were wrong
- damaging press publicity

This conflict between perceived institutional interests and the professional autonomy of the individual midwife has resulted in a climate of silencing and bullying, to the detriment of midwives, midwifery practice and ultimately of women who are deprived of best professional care. Whenever and wherever skilled practitioners are prevented from providing what women request, *'Women in that community […] lose the freedom to choose among a broader set of options for giving birth'*[18] – many of which have been shown to be beneficial.

Fear and bullying

Returning again to Marsden Wagner's article, even in 1995 the level of fear was palpable, and he gave examples of practitioners who might have spoken out to support accused midwives being intimidated and threatened. While this fear is more overtly prevalent in the US, one UK midwife told us that most of her colleagues were too frightened to give evidence during her hearing, fearing that they would be bullied next. Others have been told: 'It will go badly for you if you turn to outside help' and 'You are not to speak to us except through ...' When women organised support for a midwife, she was repeatedly accused of 'organising a targeted campaign against us'. The cost can be extremely high. The cost to women, as Marsden Wagner pointed out is the loss of options for childbearing, leaving some women feeling that they have no option but to birth without a skilled attendant. The cost to midwives is their livelihood, reputation and health of themselves and their families. One midwife told us that her NMC hearing was the worst experience of her life; other midwives have become emotionally and physically unwell; one midwife asked AIMS not to take up her case as she could feel her health deteriorating just thinking about what had happened; another midwife lost her income, home and health and 'The first thing she knew about the [NMC] trial was by reading it in the press and seeing it on the news'.

anxiety, fear and isolation when required by employers 'not to talk to anyone' about their case

We know of at least one NMC case where further charges were added after a hearing had commenced and, like Jilly Rosser, several other midwives have had to appeal to the High Court against striking-off orders. Other midwives, already under severe stress as a result of investigations into their practice, have felt increased anxiety, fear and isolation when required by employers 'not to talk to anyone' about their case. In one instance this precipitated deteriorating mental health.

Undue intrusion into midwives' lives

During investigations midwives can also face the problem of their personal medical records being subjected to surveillance at the request of the NMC. These requests are made with the threat that if midwives do not comply in releasing their medical records, they may be referred to the NMC Conduct and Competency Committee with further sanctions because of what is viewed as their non-compliance. This is an area of growing concern. Article 8 of the European Convention on Human Rights states that there must be respect for a person's private life, including 'correspondence'. In line with the convention, Article 8 of the UK Human Rights Act, 1998, states that there must be respect for one's private details which must be kept confidential, including medical records. These actions of the NMC therefore may become the basis for a legal challenge in the future about the undue surveillance of private citizens.

all of this puts women and babies at risk

While, as Marsden Wagner suggests, attacks on midwives can lead to solidarity between midwives, and others who share their values, it is very isolating for the individual midwife who bears the brunt of the attack. Babies do die. Tragic losses do occur. The midwife-mother relationship should be the basis from which both begin to make sense of this loss. Instead midwives are swept into this quasi judicial process through which they often lose the relationship with the woman that has meant so much to them and to the woman.[39] To be deprived of the relationship with the mother in this way is clearly a Human Rights issue for midwives who bear the further damage to themselves and their working status. All of this puts women and babies at risk: as mentioned previously, more women who want midwifery support are feeling they have no option but to give birth at home alone and more harm and distress are caused all round. Even if out-of-hospital midwifery care was shown to have slightly poorer outcomes than medicalised care in hospital, women should be able to make their own decisions: but medicalised care in hospital is not safer than skilled midwifery care at home or in a Birth Centre. Skilled midwifery-led care improves a range of outcomes (women are more likely to breastfeed, feel in control, and be satisfied) and reduces the use of a range of obstetric interventions such as induction/acceleration of labour, regional anaesthesia, instrumental delivery and episiotomy.[40, 41, 42]

What can we do?

The solutions, Marsden Wagner suggests, *'begin with raising the public's awareness of the witch-hunt and its basis in political not medical issues'*. His focus on these events as political in nature echoes the long history of witch-

hunts which most often took place in the midst of political turmoil where authorities tried women as witches because they saw them as a subversive challenge. This might well be said of our maternity services now (see Jo Murphy-Lawless on page 22). It makes no sense that the same group of government and government-sanctioned regulatory bodies, such as the NMC, who talk with increasing emphasis on the need for safety in maternity services, make them less safe by attacking midwives. At the time of writing, the National Patient Safety Agency, on behalf of the government, has left a crucial monitoring instrument of maternal well-being, the National Confidential Enquiry into serious morbidity and mortality, with a less certain future, and data currently being collected on an interim basis only. This is a clear example of the fragmentation of our maternity services which has contributed so significantly to the trauma of women and the dilemmas of woman-centred midwives and which continues apace. It is clear that in the broader arenas of government policy, the commitment to woman-centred care is a meaningless statement. At the other end of the spectrum, the midwives who are fully committed to the needs of pregnant women, who exercise fully their duty of care, and who work hard to update their skills, challenge these meaningless promises. Therefore, we must challenge processes, at local and national levels, which are jeopardising the ways midwives undertake their obligations. As Beverley Beech has said, the midwife should be able to have confidence in stating: 'You were not there, I was, and I made my clinical decision at the time.' It is up to us to reinforce her sense of confidence.

Nadine Edwards, Jo Murphy-Lawless, Mavis Kirkham and Sarah Davies

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Midwifery and Birth in 2011

Ina May Gaskin takes a look at the situation in the United States

If we date the beginning of the resuscitation of the midwifery profession in the US from the establishment of the American College of Nurse Midwives in 1955, we are now just a little past half a century into the concerted effort it is taking to bring the profession back after its total elimination during the first few decades of the 20th century. Bringing back midwifery in a country that forgot that it ever existed requires a kind of commitment from women – whether they be pioneering midwives or women actively calling for a midwifery model of care – that is equal to the passion and stamina exhibited by the suffragists a century ago, when they were fighting for the right of women to vote. Many laws have had to be changed, and many more laws (and minds) still need to be changed before a significant proportion of US women have access to midwifery care.

American history demonstrates well how midwifery can be destroyed throughout a country within the span of one generation – if the medical profession decides that it has a stake in eliminating midwifery. In the US, we have two streams of midwives that developed. The first to appear on the scene (Certified Nurse-Midwives) mostly attend births in hospitals. CNMs, as they are called, can be licensed in any one of the fifty states, but their organisation had to win this right a state at a time. The second stream are mostly Certified Professional Midwives (I'm one), and most of us are not previously trained or registered as nurses prior to entering midwifery. We assist most of the planned home births that take place in the US and are able to legally practice in 27 of the states.

Most of the persecution against midwives that has taken place more recently in the US has been aimed at unlicensed midwives who attend home births. As more states have passed legislation providing for the licensure of CPMs, this has reduced the number of cases of outright persecution of midwives who serve women who plan home births. However, women continue to want home births in states in which no midwives are able to legally attend them, and circumstances sometimes bring midwives into criminal court. In spring 2009, a fully certified midwife, who hadn't obtained a licence in one of the three states where she attends births, was charged after the death of a baby in her care. She plea-bargained and paid a fine of several thousands of dollars, and the case was dropped. She continues her busy birth practice.

Another case recently came to trial in California. It involved a student midwife, whose mentor wasn't able to get to the woman's labour because of another birth. When the student informed the woman that it would be necessary for her to go to hospital because her midwife was not available, the woman refused. The birth involved a shoulder dystocia and a postpartum haemorrhage. The baby was born in good condition. The student correctly controlled the haemorrhage and transported the mother to hospital, from which she was soon released in good condition. However, the student was charged and convicted of practising medicine without a licence, despite her lawyer's contention that this had been a 'good Samaritan' situation and that it would have been immoral for her to have abandoned the woman.

Midwifery care in the UK and Europe is not organised in the same way as it is in the US. In general, we don't have midwifery managers and supervisors. The oppression of nurse-midwives happens too, not so much a case at a time, but rather in job insecurity. Midwifery services can suddenly be closed without warning and for no apparent reason, or hospitals will simply decide not to hire midwives, even if women are crying out for them. Women wanting home births in New York City found out in 2010 that this choice could be taken away from them overnight, when the only hospital in the city which would accept home birth transports went bankrupt. A several-month campaign organised by birth activists finally succeeded in pushing the state lawmaking body and the governor to provide a remedy, but the lack of birth choices for women in the rest of the state remains. Obstetricians themselves can be fired in many parts of the country for willingly assisting a woman having a vaginal breech birth or for being lenient with mothers who want the option of a vaginal birth after caesarean in a hospital.

hospitals will simply decide not to hire midwives, even if women are crying out for them

We midwives who have been involved in the resurrection of midwifery in the US have been learning over the last four decades that it cannot be brought back as quickly as it was destroyed. When the home birth and natural childbirth movement launched itself in the early 1970s, several urban hospitals on both coasts began hiring nurse-midwives as a way of wooing back women who wanted alternatives to the standard medical model of birth.

Now, forty years later, midwives of some type attend about 10% of the 4.2 million births that happen every year in the US. About 1% of all births are planned home births. That doesn't sound like much, but it is interesting that between 2004 and 2008, there was a 20% increase in the home birth rate in the US. More than half of the

states reported statistically significant increases in their home birth rates during that period. Authors of a recent study on this subject pointed out that these recent increases in US home births took place before the release of a series of documentaries, news articles, and positive television reports about home births.[1] This is heartening news for us here, and we expect there will be further increases in the years to come. Just as encouraging is the fact that these increases occurred in a context of increasingly public physician opposition to the practice, with the American College of Obstetricians and Gynecologists (ACOG) issuing a policy statement opposing home birth in 2007.[2]

It's likely that there are several factors at play that account for the increased interest in home birth over the last few years. For some, home birth is a way of avoiding an unnecessary caesarean or induced labour during a period of sharply rising caesarean and induction rates. For some, it's a way of saving money, but for more, it's a way for women to move freely in labour, eat and drink if they want to, and to labour without arbitrary time limits. For many women, it is the only way possible to have a vaginal birth after caesarean, given that ACOG, in 1999 reversed its former policy of encouraging vaginal births after caesarean as an effective way to lower the caesarean rate. There is plenty of reason to believe that the home birth rate would significantly increase if there weren't so many insurance companies that refuse to reimburse pregnant mothers for home birth services.

What is strikingly different today from the situation in the 1970s is that for the first time, we have celebrities who are willing to let it be known that they chose to give birth at home. The home birth community has known for a long time that certain celebrities had home births but that they kept this secret because they worried about the impact this choice might have made on their careers. That stigma has disappeared, thanks to Ricki Lake, a popular talk show host, who went public a few years ago about the home birth of her second son. Her media connections made it possible for discussions about home birth to take place for the first time on mainstream shows without the obligatory disapproving obstetrician who was always brought in to throw cold water on any statement that might hint that people choosing home birth were making rational choices.

Most of the home births in the US are assisted by non-nurse-midwives, but a growing number of nurse-midwives are beginning to start home birth practices. Some of the impetus for this switch is probably due to the fact that nurse-midwives' jobs are less stable in some parts of the country than they used to be. Beginning in the 90s, hospitals in several cities decided to cancel their midwifery services overnight. The lion's share of federal support for the education of maternity care professionals goes to those programmes that educate more doctors. Nurse-midwifery education has the lowest priority of all the healing professions, when it comes to receiving federal dollars. For this reason, the number of nurse-midwifery education programmes has contracted rather than grown over the last two decades. At the same time, despite all of the obstacles, nurse-midwifery programmes seem to have no trouble filling every slot available with students who want to enter the profession.

how difficult it can be to avoid an induction or a caesarean

Another likely reason for the increase in home births is that the doula movement in the US has created chances for women who have never before given birth to see what medicalised birth is like in hospitals. Some doulas choose home or birth centre birth for themselves precisely because they understand how difficult it can be to avoid an induction or a caesarean. Several doulas (most are mothers) are blogging now about pregnancy and birth, and these blogs serve as today's equivalent of the childbirth classes that were the norm a generation ago. Some blogs boast of 30,000 subscribers or more, so they are a force to be reckoned with.

Science & Sensibility www.scienceandsensibility.org and Stand and Deliver www.rixarixa.blogspot.com are just two very informative, widely-read blogs that provide a forum for birth-related discussions.

The chairman of the maternity department of a major East Coast hospital recently told me that maternity units are no longer seen as the major money-making sectors of the hospital. This is one reason why Philadelphia, which as recently as 2005 had 19 hospitals with maternity units now has only six hospitals providing maternity care. The chairman remarked that with the aging of the babyboom generation, cardiology and neurology departments have become hospitals' 'cash cows'. Such drastic changes as these force the hospitals that continue to provide maternity care to take care of far more women than they were originally designed for. I was amazed at the number of huge, old computers that crowded both sides of the corridors in the hospital I was touring, where several thousand babies were born every year. I couldn't help but notice that such crowded, hard-to-clean corridors would not have been permitted to exist in a birth centre in any part of the country.

I just downloaded the latest edition of CEMACH's publication Saving Mothers' Lives (onlinelibrary.wiley.com/doi/10.1111/bjo.2011.118.issue-s1/issuetoc). I was given a copy of a previous edition more than a decade ago and immediately became curious to know what the US equivalent to this UK effort to analyse the causes of preventable maternal deaths in the UK was. I couldn't have been more shocked to learn how little infrastructure has ever been put in place to even ascertain all of the maternal deaths that take place every year. Instead of a 250+ page book published every three years, US mothers rate only a single page buried in a yearly report of outcome statistics for births and deaths. Even though we called ourselves the 'United' States and there has been a

US Standard Death Certificate ready for use since 2003, the Centers for Disease Control (CDC), our health statistics agency, has no authority to require the states to adopt its use. So far, the CDC's urgings have still not managed to convince wayward states to give up their idiosyncratic state death certificates, most of which do not ask the questions pertaining to a deceased woman's pregnancy status in the year preceding her death that appear on the US Standard Death Certificate. I'm still amazed that we would have such a document and not require its use in every state.

The CDC published an estimate in 1998 that it was possible that $^{2}/_{3}$ of the deaths that actually took place may not have been classified and counted as maternal deaths. Even with the large degree of underreporting of maternal deaths, the CDC has reported rising maternal death rates in recent years. States such as California, New York and Florida have made extra efforts to identify maternal deaths that might not have been picked up from death certificates. California reported a tripling of its maternal death rate between 1996 and 2006, attributing much of the increase to an excess of caesarean sections. The New York Academy of Medicine reported in 2008 that the maternal death rate for African-American mothers had risen to an incredible 79 deaths per 100,000 births (the national goal is no more than 3.3 deaths per 100,000).

Even though the rising maternal death rate is a story that has been censored by the mainstream media, bloggers and midwifery advocates are generally aware that the US (even with its poor ascertainment of deaths) ranks behind 49 other countries in preventing maternal deaths.

We live in an age of great superstition about technology and the female body. Women don't realise how easily they can be manipulated into making choices that they will later regret when they harbour deep fears about their bodies. Some of the superstition is embedded in the way nursing and medical students are exposed to birth in the hospital setting. I've been meeting an increasing number of nursing students who tell me that they never once during their training had a chance to be in the room with an unmedicated woman in labour. These unprepared nurses can be hired to work in a maternity ward, and if they are ever with a woman who is not yet on an epidural, they have no idea how to help her deal with her labour without calling for an immediate epidural. It's sometimes hard to believe that standards have slipped this far in only 15–20 years, but I'm talking about a common trend, now that vaginal births are decreasing in numbers in virtually all of our teaching hospitals.

My new book, Birth Matters: A Midwife's Manifesta, covers a wide range of birth-related information that should be more widely known than it is currently. In ways, I would say that we're simultaneously in the worst of times (witness the ever-climbing caesarean rate and the number of young 'educated' women who believe that it's safe to schedule birth at 35–37 weeks gestation) and the best of times (celebrities and some doctors are now choosing home birth and talking about their choices publicly). My six partners and I have all of the births that we can attend. In fact, we're not able to accommodate all of the women who would like to give birth with us. Whatever comes next is bound to be interesting.

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Campaigning in Ireland, story on page 22

Hungarian State Injustice

Donal Kerry discusses the continued persecution of Dr Agnes Geréb

Can Government inaction lead to State injustice? Can State injustice lead to the criminalisation of medical professionals simply trying to do their job and to their imprisonment and to the abuse of their human rights? Yes is the answer to all these questions, as shown by the case of Dr Agnes Geréb.

The problems started in January 1998, when the Parliamentary Human Rights Ombudsman Dr Peter Polt affirmed that the Hungarian Constitution upheld the right of mothers to home birth. The government was then expected to introduce first-time legislation to provide properly supported home birth services which parents would require. This didn't happen in 1998, or at any time until 2011.

Why it eventually took 13 years to enact legislation remains a matter of speculation but during that time parents wishing to birth at home were left with only two options: either to home birth alone without medical support or forgo their constitutional rights and have their babies in hospital. The Independent Midwives were also faced with two options: either act legally and abandon parents to the risks of bringing their babies into the world at home alone, or act illegally (unlicensed) but morally by supporting parents in their constitutional right to bring their babies safely into the world. Agnes Geréb took the latter decision and we now know that parents voted at the rate of more than 200 births a year to use Agnes's services. We also now know in 2011, after seeing the raft of court cases taken against Agnes and her midwife colleagues, just how brave the midwives were in giving their services to home birth parents.

Successive governments' inaction on home birth legislation from 1998 to 2011 meant that Agnes and her midwifery support team were discriminated against in several important ways:

1. Individual independent midwives were prevented from receiving a licence to attend home births, which, in turn, prevented them from offering their professional services legally to parents who planned to birth at home.
2. Non-hospital midwives groups could not receive official recognition as Independent Midwifery Professionals within the Hungarian Medical System, nor enjoy the normal structures/protections that other officially recognised professions (like doctors) received.
3. Independent Midwives were uniquely exposed to extended and aggressive treatment by the State Police and Prosecution Services. This was particularly acute around home birth incidences, as both these State Services applied laws and procedures that had not been altered to give proper legal effect to the 1998 Ombudsman decision.

Agnes with her midwifery team safely delivered over 3,500 babies at home yet she has faced criminal charges in the three home birth related cases where fatality arose, though in two of these the actual deaths arose some 14 and seven months (a second twin) respectively after the births. The third death arose from shoulder dystocia complications, a potentially sudden and lethal condition even when it occurs in hospital. Annually, some 56 children die of shoulder dystocia in UK hospitals and somewhere between four and seven babies in Hungarian hospitals. Yet, no doctor in Hungary has ever had to face criminal charges in connection with a shoulder dystocia case, nor hardly ever in connection with any baby's death in hospital. By contrast the Hungarian Criminal Justice System has always pursued Agnes aggressively and to date she:

- has been suspended from working as an obstetrician for three years
- has been imprisoned without trial for 77 days
- currently has been confined to over 220 days of indefinite house arrest
- and on 24 March 2011 was sentenced to two years imprisonment and suspended from working as a doctor or midwife for five years (this is currently being appealed).

Further, while imprisoned, Agnes was subjected to severe Human Rights abuses including strip searches and appearing in court in handcuffs and leg irons while being led on a chain. This treatment provoked national and international outrage and is now the subject of a court case filed against the Hungarian State with the European Court of Human Rights (ECHR). Why is Agnes treated so differently from hospital doctors? Why is she so connected with the criminal courts?

It is crucial to understand that Agnes's birth practice as a doctor or midwife has always been carried out ethically, professionally and with the sole and explicit intention of doing only what was in the best interest of the mother and baby. Agnes has never committed a criminal act and no criminal charges or convictions will ever alter this indisputable fact.

Agnes's involvement with the criminal code system comes about directly and solely because successive governments failed to introduce modern effective home birth legislation which, if in place, could have ensured that Dr Geréb or any midwife involved in birth incidents or fatalities would not normally have had to deal with these matters in the criminal courts.

Instead, like Hungarian hospital maternity doctors and all doctors and midwives in developed countries, the fatality would first have been reviewed by a professional committee of their peers. Only in the most extreme circumstances, would a birth fatality warrant referral to the criminal courts. But the absence in Hungary of

proper regulations for home birth and for the midwives who attend them means there is no Committee of Enquiry, composed of midwives, who can investigate home birth incidents and make findings.

In fact, Hungary has no proper College of Midwifery as it has only ever recognised the lesser position of 'hospital nurse midwife' as it is the doctor who remains legally and solely responsible for the delivery of all hospital babies. Independent Midwives have always had to work outside of the hospital system and have never received protection from the State systems. As a result, when birth incidents arise, these midwives are left completely exposed and defenceless to actions taken against them by the State Police and Prosecution Services, a markedly different approach from that experienced by hospital doctors. For example, no midwifery expert can be called upon by the police in any home birth incident investigation. It is a hospital maternity doctor with absolutely no home birth experience who will review the midwife's practice and recommend whether this warrants further criminal investigation and likely prosecution. Bearing in mind that the Hungarian College of Obstetricians already has a publicly stated position that home birthing is dangerous (in spite of abundant objective evidence to the contrary), it's reasonable to wonder how a member of that College can judge the midwife's actions in a just and impartial manner.

As this article points out, the current Government's viewpoint that these cases of home birth incidents are properly a criminal courts issue is clearly flawed. Its claim that Dr Geréb would receive a fair trial is shown to be false given that she has already faced the following practical obstacles when before the Courts:

- No Hungarian midwife is deemed eligible to be on the Judicial Medical Expert List and so none can testify to the court on the matter of Dr Geréb's practice.
- All the medical experts testifying in this case are Hungarian maternity doctors, drawn from the hospital professional group, who have an officially and publicly stated position that home birth is dangerous.
- All the medical experts who testified had no direct professional experience of delivering under home birth conditions.
- All medical experts called were hospital doctors who referred exclusively to hospital practices and procedures when assessing the correctness of Dr Geréb's actions, despite the birth being in a home setting.
- The trial judge declined the defence's request for independent international experts to appear in court to present their opinion on Dr Geréb's practice.
- The trial judge ruled that only the written opinion of the international experts could be presented to the court but that it would not have an equal standing to the opinion of the listed Hungarian Hospital Medical Experts.
- The judge stated that he would not be influenced by the fact that these birth case incidents occurred in the home setting.

Successive governments had chosen to ignore their responsibilities to parents and midwives by not introducing legislation and, by default, abandoning midwives to the attentions of the police and the judicial systems. Eventually, this option was challenged by the ECHR ruling of December 2010 in the Ternovsky case. The ECHR found the Hungarian Government to be in breach of its responsibilities to ensure that parents had the right to expect home birth to occur in a private and safe environment with medical services available. The Hungarian Government responded by introducing a conservative and narrow set of regulations to govern home birth from 1 June 2011. These regulations make it very difficult for many of the Independent Midwives to qualify for a licence and make it equally difficult for many mothers to meet the criteria for a home birth. Also, they omitted any structural changes to the midwifery profession or to the system of investigating birth incidents which could have lessened midwives' future exposure to the criminal code system. Nevertheless, they are welcome as they legalise the provision of home birth medical services for the very first time.

Despite the December 2010 ECHR ruling, the Government failed to acknowledge the collective responsibility of successive governments towards Agnes. Again, in early 2011, when Agnes and her colleagues petitioned the President of Hungary for a pardon because of their mistreatment by the State, the Government chose not to support the petition. These actions suggest that the Government either doesn't accept or remains unaware of its obligations to address the injustices caused by the State. It will be the job of the campaign team to engage with the Government to encourage it towards finding remedies to this situation and to persuade it of its central role in any solution. Eventually, we believe remedial actions must include support for a Presidential Pardon for Agnes and the other midwives, and also the introduction of revised legislation to allow Independent Midwives equal treatment with Hungarian hospital doctors in the matter of birth incidents.

Donal Kerry

for further information about this campaign and how you can help please contact donalkerry@hotmail.com

A Duty of Obedience or a Duty of Care?

Professor of Midwifery *Mavis Kirkham* looks at who the midwife is serving

Recent changes in society and in maternity services have had a great impact upon midwives, their management and their supervision. As well as being medicalised and technologised, maternity care takes place within large organisations which regulate the activities of their employees in increasingly great detail. The proliferation of protocols, procedures, policies, clinical guidelines and similar documents aims to lay down what midwives should do in any situation. Whilst not called rules, these documents rapidly fossilise into rules, especially when their uptake has financial implications as in the guidelines laid down by the Clinical Negligence Scheme for Trusts.[1] Risk management – the management of the risks which patients bring to Trusts – is seen as requiring increasingly close control over all employee activities.

Research shows NHS midwives are obedient creatures.[2] The more detailed the level of obedience required, the easier it is to get something wrong and the more midwives become fearful of getting something wrong, which makes them more compliant. For example, research on the impact of stillbirth upon midwives showed those interviewed to be fearful, not of providing inadequate support for the grieving parents, but of overlooking some aspect of the complex documentation required in these circumstances. Some of these midwives had been reprimanded for this, which made them and their colleagues more anxious in this regard.[3]

Added to the general fear of birth in modern society and the fear of inaction which underpins the medical model of care, midwives fear of committing organisational sins of omission creates an atmosphere around birth which can destroy the confidence of all concerned. Such fear and anxiety is corrosive and creates the worst possible physiological climate for birth. Midwives fear for their jobs and, with centralised services, the next potential employer is likely to be distant. This means that I cannot name individuals in this article.

All these pressures towards obedience and the need to protect the employing organisation are keenly felt by midwives. Employers want midwives to efficiently process women and provide a service that is formulaic rather than responsive to the needs of individual mothers. Yet midwives[4] and mothers[5] want individualised care in the context of good relationships. Midwives whose care deviates from the local routine in response to mothers can find themselves being disciplined by their employers. This is an incredibly stressful and lonely experience which has damaged many individuals.

In this context, the supervisor of midwives is in a very difficult position. Originally the inspectors of midwives, supervision was created to ensure that midwives observed the standards required of their profession.[6] In 1936 the name was changed to supervisor and the remit was widened to require the supervisor to be a 'counsellor and friend of midwives, rather than a relentless critic' (Ministry of Health Letter 1937, quoted in Jenkins 1995; 52);[7] yet she was still required to police the profession. These two requirements create a tension at the heart of supervision, though some supervisors manage that tension creatively and supportively. Now that there is such pressure from employers to ensure that midwives are obedient to local practices, supervisors are under pressure to be inspectors, monitoring and disciplining midwives to fit in with local NHS requirements.

I know a midwife who, after supervisory investigation of a case where the mother wished to birth at home, was required to do an assertiveness course in order to better persuade women to transfer to hospital according to local protocols. When another midwife was in a similar situation, mothers whose home births she had attended wrote letters of support and praised her sensitive care.

Clinical Negligence Scheme for Trusts (CNST)

The Clinical Negligence Scheme for Trusts (CNST) is the insurance arm of the NHS Legal Authority (NHSLA). CNST handles all clinical negligence claims against the NHS, regardless of the size of the claim. When a claim is made, the NHS body remains the legal defendant whilst the NHSLA takes over full responsibility for managing the claim and meeting the associated costs.

Membership is technically voluntary but currently all NHS Trusts in England belong. Private treatment and care are covered by the scheme when providing care to NHS patients via an NHS referral.

Costs are met by membership contributions. Potential claim costs are predicted in advance each year and premiums set to meet the total forecast. Contribution levels depend on things like type of Trust, the specialties it provides and the number of clinical staff it employs. Discounted premiums are available to those Trusts that achieve the relevant NHSLA risk management standards and to those with a good claims history.

The standards expected by CNST are listed at www.kingsfund.org.uk/document.rm?id=8973

Yet when these cases were examined and some found to not exactly fit the local guidelines for home birth bookings, what the mothers saw as success stories were taken as evidence against the poor midwife. Recently two independent midwives have been judged to be in need of 'developmental support' because the supervisor was unhappy with them not following NICE Guidelines on the frequency of auscultation in labour, though the guidelines are not evidence based and the mother did not want these guidelines to be followed. These cases are problematic because there is no clear pathway for appeal against supervisory decisions, unless they involve referral to the Nursing and Midwifery Council.

it is just those midwives who listen to individual women and respect their choices who are most likely to suffer disciplinary action

My own supervisor is excellent and I happily travel a distance for her valuable support and advice. She has recently been sidelined from her senior midwifery position when another reorganisation of local services required her to reapply, yet again, for her post. It is fortunate for me and other midwives that she is still a supervisor. I know another midwife who has recently resigned as a supervisor because she does not want to be 'just a management lackey', though her supervisees hold her in high regard.

Where does this leave maternal choice and the midwife's duty of care? It is my impression that it is just those midwives who listen to individual women and respect their choices who are most likely to suffer disciplinary action from supervision or from their employers. Independent midwives are disproportionately represented amongst those referred to the NMC and they are the group of midwives sought out by mothers who are unwilling to accept the standardised package of care offered to them within the NHS and who seek carers who are highly flexible and supportive.[8] In the investigations which followed one case where a baby died, the independent midwife reported being told that she 'listens to women too much' by both a supervisor of midwives and the Nursing and Midwifery Council.[8]

It is also my impression that midwives who give continuity of care within the NHS, and who thereby come to know and respect the choices of their clients, are also particularly vulnerable to close scrutiny from employers and supervisors. The closure of the Albany Practice in London and the One to One Scheme in Sheffield are examples.

When midwifery managers and supervisors are requiring a duty of obedience rather than care, who is there to support midwives who listen to women? A friend of mine, facing a disciplinary hearing for supporting a mother's choice, was recently advised by her RCM union representative to take out of her statement her consideration of the dynamic nature of practice and the need for client consent to care to be ongoing and for care to be negotiated in the light of individual women's choices.

Whilst Department of Health policy supports maternal choice,[9, 10, 11] there have always been locally defined 'right choices' and pressure on midwives to 'go with the flow' of local practices.[12] These pressures can provide a rationale for supervision if it is strong and truly independent. Recently, many cases have been brought to my attention where supervisors seem to be enforcing obedience to local practices rather than the Midwives Rules and Standards.

As care becomes standardised and midwives become increasingly obedient, they can even be judged as guilty of serious misconduct because their practice does not fit with the norm. This has happened even when the guidelines underpinning normal practice are not evidence based and a judgement of 'failure to' implement such guidelines implies a power that the midwife does not have over the behaviour of mothers who have made their own thoughtful decisions.[13]

Rules and routines sustain us, they mean we don't need to think and there isn't time to think about everything. But if everything is governed by rules, we get out of the habit of thinking and that is dangerous. Midwives continue to leave the profession because they cannot practise to the best of their ability and midwives and mothers seek relationships which are increasingly rare in standardised, centralised services. Is midwives' alliance 'with institution' now, rather than 'with woman'?

Mavis Kirkham

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German Midwives Appeal

Is it time for the future of German midwifery to change course?

The following is an extract of an interview with Nitya Runte,[1] a German midwife with 25 years' experience, about the protests German midwives made on the International Day of the Midwife last year, translated by Maggie Godsland.

The International Day of the Midwife (5 May) is traditionally a day when midwives draw attention to themselves and their situation. On 8 May 2010 a petition with almost 90,000 signatures was handed in to the German Bundestag by German midwives with the support of many parents and of the Cologne initiative 'Hebammen für Deutschland [Midwives for Germany)'.

The impact of the protest has been immense. Every day we [Midwives for Germany] receive letters and enquiries from people asking what they can do to help.

Has a grass roots initiative from the parents themselves any chance of success at present?

There are a lot of small initiatives which take up the theme and show how important it is. Countless parents have shown their solidarity by signing the petition and are collecting further signatures themselves. Everybody who hears about the situation reacts in anger and wants to help.

How would you rate the current situation for midwives?

We're about to go under. By we, I mean all midwives who offer care outside hospitals which means home births and birth centre births as well as individual care of birthing women. We intend to mobilise all our strength to change course. It's very important for the media to give us comprehensive coverage, especially during our dialogue with government institutions. This also highlights the discrepancy between the public image of midwifery and the reality.

In your opinion, will there be structural upheavals?

Yes, many midwives will become unemployed because not everybody can live off postnatal care. And the amount of antenatal care undertaken by midwives will drop drastically because of the lack of intrapartum care. So we are working on the assumption that midwives will lose even more antenatal care which is already highly contested.

Competition between midwives will become increasingly explosive. The major part of postnatal care will be taken over by midwives working within the hospital system who work in postnatal care as well as in the labour ward. More and more hospitals without a paediatric department attached will have to close. An increasing imbalance will develop between the number of state-employed (hospital) midwives and the number of births to be managed. Overtime, burnout and stress-related errors will be the result. A quarter of the births in Germany that are in the care of independent midwives will be taken over by hospitals. This means further deterioration in care on the labour ward during the birth and more interventions and surgical procedures such as caesarean sections. And there will be more insurance claims.

Centralisation and the longer journeys for labouring women will result in more women having to give birth to their child at home alone or in a car without any form of care and without the opportunity to prevent this by obtaining satisfactory support from a freelance midwife.

What will the midwifery profession look like in the future?

We will experience further American trends, namely some of the women who reject hospital 'mass production' will decide to give birth without professional help or with doulas. The latter, who have no basic medical training, are intended to be there just to support women. They will try to close this gap in service provision or to exploit it for their own ends, which would lead to further weakening of the rest of midwifery. And there would also be more insurance claims.

We are also expecting more hospitals to be taken over by big business, which means a drop in salaries. The pay of our state-employed colleagues, which is already low, will drop even further. They will be forced to undertake more part-time postnatal and antenatal care. At the end of the day there will be even less for us all!

Do you see any chance of there being a shift in attitudes politically?

Yes, there is a chance if the support of the media and the public that we have at the moment is used rapidly and to advantage. The current focus ensures that political decision-makers will also pay attention. The 'Hebammen für Deutschland' initiative will not only make demands, it will also propose solutions.

What was the strongest impression that you took away from the demonstration?

A spirit of optimism, particularly because the petition went well. And the courage to speak out more vehemently. We have noticed that midwives need to commit themselves outside the context of the trade unions. Smaller-scale initiatives bring us closer to parents and mean we can act more quickly.

Hebammen für Deutschland is an initiative to maintain the status of midwifery. *'We have developed a vision of the future for our profession. In the future, women should still be able to choose freely how they want to bring their children into the world. We aim to stop midwifery dying out in the area of independent individual care. Our initiative will give the public a complete picture of the profession of the midwife. Far too few people know that midwives are the best guarantee of a healthy start to family life.'*

abridged by Beverley Beech

Nitya can be contacted at info@hebamme-nitya-runte.de
Hebammen für Deutschland's website is www.hebammenfuerdeutschland.de

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1. Deutsche Hebammen Zeitschrift 6/2010; pages 69-70

Independent Midwifery in Australia

Joy Johnston looks at the situation at end of 2010

The good news is that a small band of independent midwives in Australia are continuing to provide midwifery services to a tiny minority of Australian mothers and their babies, most of whom intend to give birth at home.

This fact may not seem very newsworthy. However, it is significant in view of the federal government's package of health reforms that are being enacted and implemented at present. At the heart of the reform package is the mandating of indemnity insurance for every regulated health professional.

Every other regulated group, except independent midwives, is able to purchase suitable insurance. Midwives are able to be indemnified for everything we do EXCEPT private attendance at home birth – the mainstay and raison d'être of private midwifery practice. The temporary solution that has been offered, and is now in effect, is that midwives attending home births privately have been given exemption from the indemnity insurance rule until 1 July 2013.

A couple of years ago the federal Health Minister announced a Maternity Services Review (www.health.gov.au/maternityservicesreview), declaring that the Government intended to provide 'More Choice in Maternity Care – Access to Medicare [funding] and PBS [prescribing] for Midwives'. The monopoly of government funding for maternity care being available only for services provided by doctors and hospitals was to be broken. The Review's Discussion Paper acknowledged the call for radical reform and more appropriate use of the midwifery workforce by consumers and midwives, quoting the Maternity Coalition's (2002) National Maternity Action Plan, which called for all women to be able to access a known midwife who would provide one-to-one primary maternity care from early pregnancy through postnatal care, providing for births in the setting of the woman's choice, with seamless transfer arrangements when required.

Midwives and birth activists encouraged everyone who cared about birth to write to the Review. An unprecedented number of submissions were received by this and subsequent reviews. In September 2009, approximately 2000 people flocked to the national capital and rallied outside Parliament House, in the rain, with babies in slings and little children waving banners. (midwivesvictoria.blogspot.com/2009/09/more-than-2000-people-protest.html). It was very clear by then that the offer of 'More choice in maternity care' was actually '... as long as it's not home birth with a private midwife' – the very choice that many of those who wrote their stories and attended rallies were determined would not be taken from them.

Women and midwives were understandably angry

The Report of the Maternity Services Review was published in due course, and the birthing activist community was shocked. Private midwifery was apparently to become illegal, due to the impossible hurdle of mandatory indemnity insurance. Women and midwives were understandably angry. The vision of going underground arose: midwives attending women discretely and unlawfully for birth at home, and parents finding an alternate pathway for registration of their child's birth. The tone of the Report was paternalistic to the extreme; a socialist Government dictating maternity care, strongly influenced by shroud-waving risk-averse medical groups, and ignoring women's basic rights to undergo a normal physiological event, childbirth, in their own homes and on their own terms.

The Government's maternity reform package has now become law. Since 1 November 2010, midwives have been able to apply for notation on the Register as eligible for Medicare and PBS. A small number of independent midwives have achieved this new standard, and others are awaiting the outcome of their applications.

Even when a midwife is prepared to practise according to the new private midwifery model dreamt up in the rarefied atmosphere of bureaucracy, the reform 'carrot' that offered access to Medicare funding and other extensions to practice for midwives in private practice had a very big 'stick' attached – that a midwife would also be required to have a collaborative arrangement with a named doctor in order to access the funding. The clock appears to have been wound back many years to the days when all midwives were supervised by doctors.

Spokesmen for the medical profession have questioned the liability of a doctor who enters a collaborative arrangement with a midwife

Inter-professional collaboration, consultation and referral are no impost on midwives: it's a basic principle in midwifery practice that when there is a valid reason to interfere with the natural process, a medical practitioner who specialises in obstetrics is one who brings essential skills and expertise to the care team, greatly improving the outlook at that point in time for mother and baby. However, the model that has been written into Australian laws demands that the midwife obtains a signed collaborative agreement or arrangement with a doctor, without requiring that doctors reciprocate. Spokesmen for the medical profession have questioned the liability of a doctor who enters a collaborative arrangement with a midwife, fearing that their own insurance policies would not be effective if a woman sued the midwife for damages.

Without getting bogged down in speculation about how midwives will be able to navigate this untested and awkward new terrain, careful reading and interpretation of the legislative instrument seem to allow room for midwives to continue private practice without being overwhelmed by the watchful eye or hot breath of medical supervision. Pathways that are being forged include arrangements with the medical staff of public maternity hospitals, rather than with individual private obstetricians.

The constant recurring theme in Australian and international midwifery regulation is the public interest. The Australian medical profession considers obstetric supervision of all maternity care to be in the public interest, and assesses midwifery as incapable of delivering optimal and safe maternity care in settings outside obstetric surveillance. The issue of home birth is the pimple on the end of the maternity system's nose. It won't go away, it hurts when touched, and it's a real nuisance.

'Whilst mindful of a woman's right to personal autonomy and decision making, RANZCOG [the College of Obstetricians and Gynaecologists] cannot support the practice of Home Birth due to its inherent risks and the ready availability of safer birthing practices. Where a woman chooses to pursue Home Birth, it is important that this is an informed choice, considering all the benefits and possible adverse outcomes.' (RANZCOG Statement on Home Births, 2009)

When a midwife supports a woman through difficult decisions, understanding risk and the woman's bodily autonomy, she may come under criticism and threat from others, including midwives, who support the obstetric view of risk and safety. The midwife in this situation may, in fact, be fulfilling her duty of care to promote and protect normal birth in partnership with the woman.

Joy Johnston

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Witch-Hunt in France

Françoise Bardes shares news of demonstrations in favour of French midwifery

The witch hunt in France looks rather mild at first glance. Legally, midwives are entitled to help women who choose home birth; it is a legal choice here. BUT it is also a legal requirement to have insurance. Therefore we are required to be insured for a home birth practice.

The problem we have in France is that no insurance company accepts insurance for home birth practitioners. If they do, they set it at such a price (25,000 euros) that it is impossible to pay that amount, as it is the average yearly income for midwives. It is a rather schizophrenic situation!

So, home birth midwives just practise without insurance.

If a problem arises, the legal defence is not paid for by any professional association, so it is the midwife or an association of her clients who pay the lawyer (their fees are a lot more expensive than those of midwives).

Sometimes an obstetrician or another practitioner spots a home birth midwife and reacts violently against her. This has happened to a few midwifery colleagues. One was visited by the local midwifery authorities (l'Ordre des Sages-Femmes): they intimidated her to stop her practice, threatening litigation. One was sued, and has stopped home birth (but recently she was able to get insurance from Switzerland and she is about to resume her home birth practice).

It is most disheartening to see that the danger is mainly within the midwifery profession

It is most disheartening to see that the danger is mainly within the midwifery profession. L'Ordre des Sages-Femmes attacks their home birth colleagues rather than coming to their defence.

No lobby is strong, or willing, enough to stop this crazy situation and put pressure on the State and the insurance companies so that home birth becomes really legal.

One can see the very strong lobby of doctors and obstetricians wishing to eradicate home birth in France.

In spite of these hostile conditions, midwives and women bravely go on having home births.

There has been a recent strike and street demonstration in Paris of angry midwives. For the first time in the recent history of home births, different midwifery unions, alongside the 'Conseil de l'Ordre', agreed to ask the Minister of Health to find a way to insure home birth midwives and legalise birth centres.

Since 2002 our wages have decreased. Of all professionals acting in health (such as nurses and physiotherapists) we have the lowest income and since we are earning less and every cost has gone up it is even worse.

The Government is cutting down expenses in every public institution, so that midwives working in hospitals are under strong pressure: fewer midwives, more births.

Therefore we started a campaign in 2010: a demonstration in black: we were mourning our dying profession. See www.youtube.com/watch?v=fINFkmtU42c&feature=related

This year 3500 midwives demonstrated in Paris streets. There are 23,000 midwives altogether in France. See www.youtube.com/watch?v=HqrAiwIq15c (one of the songs went: 'Carla, when you give birth there will be no midwives left')

Parents came to support us: mdncalm.org/activites/le-calm-soutient-les-sages-femmes

The answer from the Ministry of Health has been very disappointing, so midwives are looking for more punchy actions to succeed in their quest to secure insurance and support for home birth.

We foresee more action on the 4th of October.

Françoise Bardes
sage femme liberale (independent midwife)
and home birth midwife

A dying profession?
Protests in support of French midwifery

Moves to Transform Maternity

Mary McNabb and Christina Oudshoorn explain the changing care in the Netherlands

A new system of maternity care is under discussion in the Netherlands. The Dutch Society of Obstetrics and Gynaecology (NVOG) recently published a position paper arguing for the need to abandon the current divisions between primary, secondary and tertiary care, in favour of an integrated system that would bring obstetric, midwifery, paediatric, anaesthetic and social care provision, into a number of regional centres. The proposed centres would be liable for the professional, legal, financial and organisational management of care provided to women and their partners, from preconception to lactation, both at home and in hospital.[1]

To improve working relations between midwives and obstetricians, proposals have also been made for both professions to be educated at university level. Bringing midwifery education to the same level as that of obstetrics is designed to foster a higher degree of mutual respect and recognition of their distinct but complementary fields of scientific knowledge and professional expertise.[2] Shared learning of common core subjects, by midwifery and obstetric students, would make it easier for them to work under the proposed unified umbrella. In addition, greater knowledge of fetal medicine, reproductive pathologies and obstetric technologies would be very appropriate for the growing number of midwives working as specialist practitioners, in general hospitals and perinatology centres.

The proposed integration of primary and secondary levels of care implies that midwives currently working as autonomous primary care professionals would take on a dual role. In addition to facilitating the bio-social processes of reproduction in healthy women, they would need greater knowledge and expertise of obstetric technologies, to diagnose and monitor complicated pregnancies and supervise women in secondary care, undergoing routine obstetric interventions, during labour and birth. The proposals for university-based education are clearly designed to equip midwives to undertake the second role. However, they do not include any knowledge of bio-social, emotional and neuro-hormonal adaptations to reproduction, which is essential for midwives to function as primary care professionals, for women who choose to have a drug-free labour and birth. This knowledge forms the scientific basis for midwives to develop a progressive awareness of women's individual responses to different phases of pregnancy and establish a trusting relationship, particularly during the third trimester, in preparation for the coordination of maternal-fetal neuro-hormonal systems that regulate the transition to labour, birth and lactation.[3, 4, 5, 6, 7, 8]

Why now?

The main reason for the proposed changes in the structure of maternity care is the growing involvement of obstetricians in supervising pregnancy and birth in women who do not have any underlying pathologies.[9]

In 2008, 32.9 percent of births took place in primary care and 21.5 percent of these took place at home, while 67.1 percent of births took place in 85 general hospitals and 10 perinatology centres. Hospital births are supervised by obstetricians, junior and senior residents and hospital-based midwives. Independent primary care midwives provide care for their own clients, in hospitals, as a 'home birth away from home'.[10, 11]

The NVOG claims that 76 percent of all pregnant women are currently referred to obstetricians and the rate for primigravid women (those expecting their first baby) is even higher, with 84 percent starting pregnancy with primary care midwives, but 80 percent are eventually referred to an obstetrician.[1] These unsupported statements are much higher than the most recent data from the primary midwifery register.[10] In 2008, 84 percent of primigravid women started pregnancy with midwives, in primary care; 36.5 percent were referred to an obstetrician during the pregnancy and 15.2 percent were referred during labour.[10]

Recent data on live, singleton, head-first, vaginal births taking place under the supervision of hospital-based obstetricians suggests that a rising number of low-risk women are giving birth in hospital. Between 2000 and 2007, the number of women in this category almost doubled.[12] Obstetricians are now supervising vaginal births by normally healthy women following an uncomplicated pregnancy, because epidural analgesia is now being offered as a consumer item, to eliminate the painful sensations of labour and birth. Obstetricians are promoting this as an 'easy birth', eliminating the physiological stress of labour for mother and fetus.[13, 14]

As a result of the availability of epidurals on demand, many more low-risk women are being supervised by obstetricians in secondary care, which has high-tech facilities designed for high-risk women. At the same time, women who are transferred from primary to secondary care because of possible complications are erroneously being categorised as 'low-risk'.[15] The expanding scope of obstetric practice, from managing pathological conditions and labour complications, to the routine use of interventions and pharmacological pain relief in labour, has blurred the previous distinctions between primary, secondary and tertiary levels of care.

Perinatal mortality

Another important reason for the NVOG proposal relates to national policies to reduce perinatal mortality. In two consecutive comparative studies of routine statistical data from 1999 and 2004, the Netherlands had the highest and second highest rate of perinatal mortality among European Union (EU) member states.[16, 17] Since

the second report was published in 2008, much debate has taken place among senior health care professionals over possible causes of the relatively poor position of the Netherlands.[18] In addition, questions have been raised about the accuracy of professional registers in the Netherlands during this period, as mortality rates differed from those recorded in the civil registration system.[17, 19, 20] Other critics have questioned the reliability of comparing national registers with differing definitions and accuracy of the data.[19, 20, 21, 22]

National epidemiological data

In absolute terms, perinatal mortality has fallen significantly over the last 40 years but the rate of decline slowed down from the 1980s. This trend has also occurred, to a greater or lesser extent, in other EU member states.[18] A national cohort study of births from 2000-2006 demonstrated a steady decline in perinatal mortality, in both low- and high-risk groups, except very pre-term infants. This has happened despite a rise in the number of risk factors, including a very high percentage of older nulliparous (women pregnant for the first time) women, more births to women from non-Western (immigrant) ethnic groups and increased rates of multiple births.[18, 23] Term infants born at home have consistently shown the lowest mortality risk.[9, 19, 23, 24]

Detailed analysis of the Netherlands Perinatal Registry has identified ethnic differences in fetal mortality; a significant increase in the number of extremely pre-term infants, particularly from 2005 to 2006; and significant regional differences in perinatal mortality, in term and pre-term infants.[24, 25, 26] Significant differences in perinatal mortality have also been identified between disadvantaged and advantaged urban areas, particularly in major cities such as Den Haag, Amsterdam, Utrecht and Rotterdam. These differences in perinatal mortality and morbidity are strongly associated with the chronic health problems and psycho-social stress experienced by young women living in poor quality inner-city environments.[27]

Taken together, these findings indicate a complex variety of factors underlying current trends in perinatal mortality, in different population groups, in urban and rural regions of the Netherlands. Recent data show a significant rise in the number of pre-term infants, who make the largest single contribution to overall perinatal mortality and morbidity rates.[25, 28]

The increased risk of fetal mortality associated with higher rates of pre-term and low birth weight infants, among women from Africa and South Asia, and also among women with a low socio-economic status (SES), from the northern region, which has the lowest proportion of non-Western groups, suggests the need for localised policies to address the distinct needs of different population groups.[26]

Government priorities

The recent NVOG proposals for a unified maternity service, covering both home and hospital births, are the latest in a series of national policies to deal efficiently with the most costly and visible problems associated with the rise in socio-economic and medical risk factors, among different population groups in the Netherlands.[24, 25, 28] The overall policy shift is designed to increase fetal screening for congenital abnormalities and routine medical surveillance of pregnancy. A 24-hour obstetric-paediatric-anaesthetic hospital service has also been set up, in general hospitals, so that all women who are admitted to secondary care receive the same level of expertise during labour, birth and early lactation postpartum.[29]

Increased medical surveillance of pregnancy and labour

In 2008, the Government appointed a Steering Group to undertake a comprehensive review of maternity services and make realistic proposals to reduce perinatal mortality.[30] The report made specific recommendations to improve the organisation and delivery of prenatal and intrapartum care for all women. These recommendations were primarily directed to increasing the speed with which women needing acute treatment are able to obtain prompt and efficient responses, in primary and secondary care. The main objective is to reduce the level of 'avoidable mortality and morbidity' for mother, fetus and neonate by 50% within the next five years.

Although the Steering Group produced a detailed review of recent epidemiological research findings on the complex socio-economic and cultural factors responsible for current trends in perinatal mortality and morbidity, the main recommendations have been limited to the organisation and delivery of care during pregnancy and labour, as this complies with the government directive for realistic, short-term solutions. While the report outlines a national pre-conception programme to identify risk factors among underprivileged women and their partners, no indications are given about how this could be achieved.

Rational management of growing risk factors in mass populations

Government policies to deal with perinatal mortality have allocated increasing power and authority to hospital based obstetricians.[31] The importance given to reducing avoidable mortality and morbidity has focused attention on care provision that can effectively manage the increasing number of risk factors, associated with recent socio-economic and cultural changes that have affected the character and pattern of reproduction in the Netherlands. The form of care that seems to be favoured by government is increasing techno-obstetric surveillance of pregnancy and routine interventions during labour and birth.

A defining moment for midwives and women

Midwives have not yet responded to the NVOG proposal to establish an integrated system of maternity care. Since the shift towards routine obstetric management of birth in hospital is well established, midwives already employed in secondary care (25.4 percent) may welcome proposals to further medicalise their education, to enable them to develop their specialist roles as obstetric nurse-midwives. For the majority of midwives working in primary care (74.6 percent) the situation is quite different. At present, 54.8 percent of independent midwives are entrepreneurs with financial shares in (group) practices and a further 17.2 percent are

employed as locums or employees by independent practices. In 2010 there were 510 independent midwifery practices in the Netherlands.[32]

To retain their bio-social approach to pregnancy and birth, these midwives need to reject the NVOG proposal for an integrated system and recommend a separate educational pathway, so that they can work from a distinct knowledge base within the newly expanding fields of bio-social and neuro-hormonal sciences of reproduction, to create conditions that complement maternal-fetal-neonatal adaptations across the fertile cycle.[3, 4, 6] During pregnancy, maternal brain alterations heighten emotional sensitivities and enhance the need for trusting relations and close social bonds.[3, 4] Maturation of fetal organs stimulates the transition from pregnancy to labour, which leads to the release of central and peripheral oxytocin, by mother and fetus. Maternal brain oxytocin induces powerful feelings of love, while oxytocin in the fetal brain acts as a natural painkiller and protects the immature brain from the transient fall in oxygen and glucose around the time of birth.[33]

Few women currently participate in discussions about the proposed changes in the system of maternity care. Ouderschap, a small group of women who work with the Royal Organisation of Midwives (KNOV), has decided not to support a petition drawn up by midwifery activists to question government plans. At present, it seems that the KNOV is primarily interested in preserving harmonious relations with obstetricians, while obstetricians are loudly proclaiming the 'backwardness' of the traditional Dutch reliance on 'nature'.[31] The future is unclear. Will independent midwives accept the dominance of a medical paradigm for the sake of harmony or resist for the sake of maintaining conditions for women who choose to experience the safety and pleasure of a drug free birth?

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Mary McNabb and Christina Oudshoorn

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Childbirth Adrift in Ireland

Jo Murphy-Lawless comments on the Irish situation

On the 21st of April this year, during a lengthy debate on the Nurses and Midwives Bill in the Irish Dáil (parliament), the junior Minister for Health, Kathleen Lynch, defending the need not to make any further amendments to this bill, made the following speech:[1]

'I believe being pregnant and having a baby is not a medical condition. I hope as many women of a particular age as possible can meet with the joyous experience of this natural condition. We need to make it clear that it is not something to be terrified of. Although I do not believe our maternity services are in crisis, having had some interaction with them recently, I accept they may be a little overstretched. That can happen when there is an influx of people having babies at a particular time, for example. It is dangerous to use the word "crisis", especially when one is talking about people who are vulnerable as they prepare to have babies. I do not think we should encourage women to panic. I believe in telling them the truth, but not in causing them to panic.'

Dáil Éireann, 2011

Lynch stated these views to three other TDs (members of the Irish parliament) in an otherwise empty chamber. The public gallery however was very well-attended that day, with people from the childbirth groups including AIMSI, Birthchoice Clare, the Doula Association of Ireland, and the Home Birth Association, as well as the Community Midwives Association, an observer from An Bord Altranais (the regulatory Irish Nursing Board, analogous to the Nursing and Midwifery Council in the UK, but with no mention of midwifery in its title), and midwifery lecturers from the School of Nursing and Midwifery, Trinity College Dublin. Perhaps most importantly for the future of childbirth in Ireland, and most numerous in attendance, were a great many undergraduate midwifery students and some of our newly qualified midwives from the new midwifery degree course begun only five years ago. Over thirty first-year midwifery students were there to hear Lynch's description of our maternity services as 'a little overstretched' because of an 'influx'. They heard the rationales about 'truth-telling', and were there to witness the proposed amendments to the Nurses and Midwives Bill being defeated. The students were actually meant to be in class with me that morning, revising for their sociology examination. However, they all said that mounting a protest outside the Dáil first and then attending the debate were priorities and that they could always email me about the exam paper.

They were absolutely right. The debate that day enabled them to understand with greater clarity than any lecture I could have given them on what the French philosopher Michel Foucault means when he writes of 'coercive power' and 'regimes of truth' and how these notions help us to lay bare what is happening within current Irish maternity services. The students urgently need to know why the retrieval of midwifery that genuinely responds to women's felt needs in birth is such a difficult project. In his 1983 lectures on truth-telling, Foucault writes that the process of truth-telling has certain requirements. For the person who would be a 'truth-teller' it is a fundamental requirement both that the speaker is 'sincere' in her belief and that the belief is also the truth.[2] This differs significantly from a 'regime of truth' which is the way coercive power reinforces a series of deep untruths.

The previous week had seen a perfect storm of adverse events surrounding childbirth and the maternity services, concertinaed into six brief days. These included:

- The settlement in full with apologies of a High Court case taken by the widower of Tania McCabe against Our Lady of Lourdes Hospital Drogheda, the Health Services Executive (or HSE, the overarching health authority in Ireland) and a consultant obstetrician, about the negligent care that had led to Tania's death and the death of one of their twin sons in March 2007. Tania was admitted to hospital on the 6 March after her waters had broken three months before her babies' due date. She was discharged from hospital without a proper diagnosis and readmitted the following day in labour. Although the twins were delivered by Caesarean section, only one twin survived and Tania died from septic shock.
- The publication of the inquiry report by a panel appointed by the HSE into the scans misdiagnosis debacle,[3] revealed in June 2010, when a mother, Melissa Redmond, said publicly that on the basis of one transabdominal ultrasound, she had been told she had miscarried in very early pregnancy, was issued with misoprostol and told to return in two days for an evacuation of retained products of conception (ERPC) to have the fetus removed. Melissa hesitated, feeling she was still pregnant (she had had four previous miscarriages) and sought a second scan elsewhere which confirmed the fetus was alive. At the time of her going public, Melissa was the proud mother of a three-month-old son. The HSE at first said this was a 'rare' event and that Ireland remained one of the 'safest' countries in the world in which to give birth, but when more women came forward with a similar account amidst considerable press coverage, an inquiry was instituted. The eventual report stated that Irish consultants and registrars, who were responsible for the vast majority of misdiagnosed cases, remain poorly trained in using ultrasound and that the equipment in many settings is out of date. The report admitted that under its terms of reference, a

review of the previous five-year period identified 24 cases of miscarriage misdiagnosis. Misoprostol was prescribed for eight women while six women had an EPRC. Twenty-two women went on to give birth, with two women miscarrying after their diagnosis. There is now an issue of compensation for the women affected.

- A death in rural west Cork of a baby born at the side of the road after its mother went into labour and was attempting to meet the emergency services to transport her to the nearest maternity hospital in Cork city, approximately fifty-two miles away. There has been an ongoing demand for home birth in the west Cork region precisely because women fear the long drive to Cork in these circumstances.
- Another baby born at the side of the road in County Monaghan to a woman trying to get to the nearest maternity unit twenty-five miles cross country in Cavan General Hospital. Since the closure of the maternity unit in Monaghan in 2001, the numbers of babies 'born before arrival' have inevitably increased in this northeastern county.

These disparate events are symptomatic of a maternity service that has been in disarray for some time. There is an historical problem of an embedded and deeply conservative obstetric profession which has remained largely unchallenged as the central influence on all levels, from the individual women to hospital policies to national policymaking. In the 1980s, when midwives in the UK were beginning to radically rethink their approach to birth and trying to retrieve their role as principal carers for women, Ireland was subjected to wholesale emigration of younger midwives. They might have made a difference here, but as a harsh recession took hold, there were simply no jobs. When Ireland entered its so-called 'Celtic Tiger era', some did return and were able to support a small group of midwives who had remained behind, to begin to push for change. Significant policy shifts slowly took shape under their determined actions, including the institution of a small number of midwifery-led initiatives and a four-year undergraduate direct entry midwifery degree (which began in 2006). However, the value of this work in challenging entrenched patterns is now being undone by a series of interlocking factors, topped off by the economic collapse. Some of the immediate issues facing Irish maternity services include:

- A steady increase in the numbers of women giving birth since 1998.
- Birth rate of 17 per 1,000 population, the highest of 27 EU countries in 2008, representing a 37% increase since 1998.
- Current total fertility rate is the highest in the EU at 2.07.
- According to the most recent Cuidiú national survey, high rates of routinised interventions, impeding women with low-risk profiles from having normal births. For example, rates of induction for all mothers attending the three biggest units in the state range from 23.3% to 30.4%, and for first-time mothers, from 27.8% to 36.9%.[4]
- Latest available information records the overall Caesarean section rate at 27%; the instrumental delivery rate stands at 16.7%.[5]
- Initial antenatal consultations can be as short as 10 minutes, even for first-time mothers.
- Many of these initial consultations may come in the second trimester of pregnancy rather than the first because of shortages of resources and women are advised to book early.
- Only 35% of hospital-born infants are born in an accredited Baby Friendly hospital despite this international evidence-based initiative being in our health service policies since 1994.
- Our maternity units have been subject to a public services employment embargo since 2008. According to a KPMG study of the three Dublin maternity hospitals in 2009, they were 293 staff short of what they require for safety.[6]

Matters have deteriorated still further since the KPMG study in respect of overcrowded facilities, cutbacks in budgets, and reduced staffing levels, leading to:

- the withdrawal of the DOMINO scheme in the Rotunda Hospital,
- the proposed withdrawal of the DOMINO / home birth scheme in Wexford General Hospital,
- and the Cavan midwifery-led unit also being under threat of closure while all units struggle to maintain basic services for women.
- Water birth is not available in any RoI maternity unit. Only labouring in water is available in just three settings: our two small midwifery-led units, Cavan and Drogheda, and in Cork University Maternity Hospital since February 2011.
- The Rotunda Hospital, one of three largest in the state, built a special purpose water birth pool in 2006 which the hospital never used, and which has just been dismantled.
- 'Virtual wards', beds in corridors, are being used to accommodate overflows from postnatal wards, with beds borrowed from other hospitals.
- Postnatal support is negligible within the community, leaving women, especially first-time mothers, unsupported at a critical point in their lives.
- The AIMSI 2010 national survey indicates widespread unease and dissatisfaction of women with our maternity services.[7]
- Many of our newly qualified four-year-degree midwives, who are urgently needed to bring staffing levels up to complement, and who have fresh views, are unable to find work and are emigrating.
- In respect of home births, our rates have declined since 2000, standing at 0.2% of all births.
- Our handful of remaining independent home birth midwives were offered insurance cover through the

state Clinical Indemnity Scheme by the HSE in 2009, but this cover was tied to a restrictive Memorandum of Understanding that was not evidence-based. For example, the agreement forbids a midwife undertaking a VBAC at home and also states that a woman whose membranes have been ruptured for more than 24 hours must transfer to hospital.

This dreary barrage translates to escalating problems for women trying to steer their way through maternity services which are in the main having to process women, rather than care for them and work with them. Surviving training in such straitened circumstances, where continuity of carer and woman-centred care are minority experiences, is disheartening and deskilling in equal measure for midwifery students. Hence our visible presence in the Dáil on the 21 April was meant to convey to our legislators and government how serious the situation is. Hence, too, their dismay as future midwives, as they listened to a Minister, backed by her officials, who denied the realities engulfing the services, who denied the need for midwifery autonomy, who backed the vested interests in consultant-led care, and who was prepared to dissemble to women facing those services that there is no 'crisis'. There was no truth to be had in the Minister's flaccid speech, quoted above. This Minister is not a 'truth-teller' anymore than are the HSE officials and obstetric consultants who promise that Ireland is one of the 'safest places in the world' to give birth while they cast adrift midwifery-led care.

The specific legislation being debated that day comprised two crucial amendments to the Nurses and Midwives Bill, a bill meant to reverse the damage of the historical sidelining of midwifery in the Republic, replacing the 1950 and 1985 Nurses Acts in which midwifery was not even defined as a separate profession. We sought to amend Section 24 of the Bill, in which a new Board was being proposed to oversee the two professions but in which there was no guaranteed and binding midwifery presence about matters to do solely with midwifery. We wanted a midwifery committee to advise the overall Board with binding effect about purely midwifery issues.

Most importantly, with Section 40, we wanted to have deleted the phrase 'who maintains adequate clinical indemnity insurance in accordance with the rules'. What the Section proposes is that it become a statutory requirement that all practising midwives carry indemnity insurance. If this section remained unamended, it would mean that any midwife who practises and is uninsured can face criminal proceedings with a potential fine of 100,000 Euros and a ten-year prison sentence. No such draconian measure applies to any other health care profession, including doctors. A very long campaign had been fought to persuade the Department of Health officials and two governments that this would result in the criminalisation of midwifery. The situation is most acute for independent midwives who can only access insurance at present if they sign up to the Memorandum of Understanding (MOU). The implication of Section 40 as part of a statutory instrument would mean that the independent midwife who accepts, for example, the care of a woman for a VBAC at home, not only removes herself from any insurance cover because she then reneges on the MOU, but also now faces prosecution for the criminal act of practising without insurance.

One TD, Caoimhghín Ó Caoláin, argued our points accurately and in depth and demanded a full Dáil attendance to vote on both Sections 24 and 40. Our hard-fought-for amendments to Section 24 were duly defeated and, to end a calamitous week, so was the amendment to Section 40. The students wanted to conduct a silent protest at the point when the vote was taken on Section 40. We all moved round in the visitors' gallery so that, as a seamless whole, our group faced the government benches below. As the tally came through, ninety TDs for the Section unamended, twenty-three only voting to amend it, we slowly stood as one and turned our thumbs down.

The Bill will become law in the autumn. Women will face poorer services than ever, with very little room to opt for a saner form of midwifery care within the institutions and very little chance outside them. Amongst other implications, it means that if a previous VBAC mother or any mother with an MOU risk profile wishes to be cared for at home, or if she wishes to be accompanied by an independent midwife in a transfer situation from home to hospital, because of a range of circumstances, such as a long journey from a more remote rural area like west Cork, then the uninsured midwife will face regulatory inquiries and criminal charges with an automatic striking off.

The 21 April was a black day and many students came out in tears, yet defiantly determined to maintain their passion for genuine midwifery and good birth. If Ireland does not want them, they will be amazing midwives for women elsewhere. For those who stay, we are on our way to court with this legislation.

Jo Murphy-Lawless
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Insurance Issues and the Future for Independent Midwifery

IMUK's *Annie Francis* highlights the current position

In the Spring of 2011, Independent Midwives UK (IMUK) was given the latest deadline for the implementation of mandatory professional indemnity insurance (PII) for all healthcare professionals in the UK.

The difference this time is that the deadline, Autumn 2013, is unlikely to be postponed or delayed any further because the vehicle is the EU (European Union) Council of Ministers Directive on the application of patients' rights in cross-border healthcare. For all independent midwives in this country, who cannot currently access any form of insurance because of a market failure to provide it, the relevant section is Article 4.2d which requires Member States to ensure that systems of professional liability insurance are in place for treatment provided on their territory. The UK Government ratified this Directive on the 28 February 2011 and full implementation is required within thirty months, i.e. September 2013.

Leaving aside the unknowns (complete financial meltdown of the EU for example) this means that all midwives in independent practice in the UK will need to be able to access PII from September 2013 in order to be registered with their regulatory body, the NMC. Without registration they will not be able to practise midwifery legally. Independent midwifery will disappear unless a solution to the insurance conundrum is found.

This news comes as no surprise to those of us who have been working on finding such a solution over many years, but the clock is now seriously ticking and it is a source of growing concern that, despite a solution having been identified which apparently has the backing of all parties involved, in effect, there is still no mechanism for implementing it and, until there is, we are actually no closer to accessing indemnity than we were at the start.

So what is this solution and how would it work? Essentially, independent midwives need to form a social enterprise, co-operative or other acceptable organisational model, with the necessary governance, guidelines and structures in place to enable them to contract in their services to the NHS through the 'Any Qualified Provider' route. As a recognised Provider, they will then be able to offer their midwifery services to women in the NHS and will be eligible to access indemnity through the NHS Litigation Authority (insurance) scheme currently known as the Clinical Negligence Scheme for Trusts (CNST).

This is the route IM UK has taken, in close co-operation with other professional and consumer organisations. The stakes are high: if we are successful, we will have created a national midwifery organisation, supporting a network of local, community-based neighbourhood midwifery practices whose midwives will be responsible for ensuring joined-up care for women that follows a well-integrated pathway and includes high-quality obstetric input when required. We know that when women are well supported through their pregnancies by midwives they know and trust, the need for intervention is reduced and the likelihood of a positive, empowering experience of birth is greatly increased. We also know that when midwives are able to build relationships with women and practise the full range of their skills as autonomous practitioners in a supportive environment they are more likely to get job satisfaction than when working in a fragmented and impersonal system and less likely to suffer stress-related ill health.

It seems to be a win/win situation

It seems to be a win/win situation. Becoming an alternative provider of midwifery services through this route means that independent midwives will be able to continue to offer the same high-quality continuity of care in much the same way as they do now. The difference is that women will no longer have to pay for it. It will be 'free at the point of delivery' and thus available to those who do not have the resources to currently access it. Before we start celebrating though, there is a problem:

The Department of Health is tasked with finding the precise mechanism to enable IMUK and other alternative providers to join the CNST scheme. There are some major issues to be sorted out, not least the question of continuing cover (for when organisations dip in and out of the scheme) as well as the need for a fundamental overhaul of a system which is coming under increasing criticism from all quarters of the health service as the cost of litigation continues to soar. We are only one tiny part of the overall picture and so must shout very loudly to ensure we don't get lost or forgotten about until it is too late.

I feel very strongly that, despite the huge amount of work required and the inherent risks attached, there is also a very real opportunity here; not only to save independent midwifery but to actually create a way of providing it that is available to more women and protects the individual midwife much more than our current

situation does. The absolute requirement, though, is for some 'blue sky' thinking, not getting trapped by old ways of doing things, and using the current climate of opportunity (including the RCOG's recent call for more 'out of hospital' births) as just that.

Those of us engaged in this difficult task have some crucial backing from deeply committed supporters who understand the value of what we currently offer and do not want to see independent midwifery disappear. What we must do is harness this groundswell of support to ensure that our voice is heard loud and clear in the corridors of power and that the result is a sustainable future for independent midwifery, complete with affordable and appropriate indemnity so that any user of our service has access to redress should it be needed.

Annie Francis
Board member, Independent Midwives UK

Take Action Now

Independent Midwives UK is working on the only viable solution, so far, to the problems of obtaining insurance. Many women, often as a result of their previous experience, know that the most important thing for them is continuity of care with a midwife they have chosen and that this option is almost impossible to find in the current NHS system. By engaging a midwife themselves they have the opportunity of determining the kind of care they want. Write to the Department of Health and ask them when access to CNST (Clinical Negligence Scheme for Trusts) will be available for IMUK as an alternative midwifery provider. For more information see www.independentmidwives.org.uk/ Sign their postcard campaign and/or, if you are a midwife, sign up as interested in working in this way in future.

IMUK Perinatal Mortality Review

Symon A, Winter C, Donnan PT, Kirkham M (2010). Examining Autonomy's Boundaries: A Follow-up Review of Perinatal Mortality Cases in UK Independent Midwifery. Birth 37(4):280-7.

This study is a follow-up to a large-scale UK study published in 2009 which found a significantly higher risk of perinatal mortality among the babies of women who had booked with an independent midwife (most of which were planned home births) than among women who had received NHS maternity care (most of which were planned hospital births). However, the raised risk of a baby dying was due entirely to 'high-risk' pregnancies; among women with low-risk pregnancies, the risk of a baby dying around the time of birth was not significantly different whether the woman received care from an independent midwife (IM) or from the NHS.

This study set out to establish whether the 15 perinatal deaths in the IM group which occurred at or after 36 weeks of pregnancy were attributable to care provided by the IMs. This was done by reviewing the (anonymised) case notes and conducting one-to-one interviews with the relevant IMs. The study was limited by the fact that only the IMs were interviewed and the views of the mothers/their partners were not sought. The views of other health professionals were included via case notes but they were not interviewed as part of the study.

Among the 15 perinatal deaths, just one of the pregnancies was classed as 'low-risk' at the start of labour – the group included four women expecting twins, three women planning VBACs and three women with babies presenting by the breech. Eight of the women had refused at least some antenatal screening, so may not have been fully aware of their pregnancy risk status. Several were fearful of accessing NHS care: two women who wanted a home birth declined the IM's advice to transfer to hospital during labour, and the IMs felt that six would 'definitely or probably' have birthed their babies unattended if they could not have had an IM.

For seven of the fifteen perinatal deaths, all the professionals involved were in agreement that the death would have occurred regardless of the way in which labour was managed. In the other eight cases, it was felt that an elective Caesarean may have resulted in a live birth. Seven of these eight women had been offered an elective Caesarean but had refused, several because of traumatic experiences in previous births. In the eighth case, there had been no clinical indication for an elective Caesarean.

In two cases, the IM was referred to the Nursing and Midwifery Council. In four cases, the IMs were of the view that problems in communication on transfer of care from home to hospital may have contributed to the outcome. IMs perceived that hospital staff had no sense of urgency when labouring women transferred from home to hospital and acted as though the woman's labour had just started.

The results of the 2009 study elicited a predictable response, with questions being raised about whether pregnant women should be 'allowed' to make choices that go against medical advice. In their discussion, the authors highlight this dilemma, making the point that, in the UK, the fetus has no legal status, so a mentally competent pregnant woman has a legal right to make choices that may increase the risk to the fetus from a medical viewpoint (bearing in mind that it is impossible to predict exactly which pregnancies will have a negative outcome). To keep matters in perspective, they also point out that the vast majority of so-called 'high-risk' pregnancies under the care of IMs had a positive outcome.

The authors' final discussion point is that the NHS should seek to understand why some women are so traumatised by their pregnancy and birth experience that they completely reject 'standard' NHS care in subsequent pregnancies. Furthermore, they state that, if informed choice in health care is to become a reality, clinicians must accept that sometimes pregnant women will make choices that take the clinicians out of their comfort zones.

Andrea Nove

JOURNALS & BOOKS

AIMS Journal: A quarterly publication spearheading discussions on change and development in the maternity services, this is 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

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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 them. Invaluable for expectant mothers and professionals alike. See AIMS website www.aims.org.uk

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

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