AIMS JOURNAL

Raging Hormones–the Power of Birth

Volume 31, Number 4
2019

AIMS

The Association for Improvements in the Maternity Services

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Vol:31 No4
AIMS Journal (Online)
ISSN 2516-5852

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Editorial

Hysterical women and their hormones

by Emma Ashworth

The suffix 'ectomy' means means to surgically remove a part of the body. So, for instance, removal of the spleen is known as a splenectomy. Removal of the appendix is called an appendectomy. Removal of the uterus is called a uterectomy.

Only it isn't. The word 'hysteria' comes from Greek roots. The word, 'hystera', meaning womb, gave us our words, 'hysterical' and 'hysteria' because doctors believed that 'hysteria' was caused by a flaw in the uterus. So, doctors were not removing the organ per se, but instead they were taking away the woman's perceived hysterical nature, and so still today if our uteri are removed from our bodies, we are still referred to as having our 'hysteria' removed.*

This underlines the historical perception of women and hormones. No matter that men have hormones. No matter that every human, animal or multi-celled plant cannot survive and thrive without hormones.

And yet, hormones are used medicinally as powerful drugs. Some people with diabetes require artificial insulin for their health and survival. Other people with lowered thyroid function need artificial thyroxine to keep their body functioning well. And occasionally, during birth, artificial oxytocin may be beneficial to mother, baby or both.

Somehow, our body's own hormonal systems continue to be maligned, yet artificial versions of hormones seem to be a medical panacea. And somehow, with artificial oxytocin, very often it seems to be 'the more, the better'. We know how dangerous excess amounts of insulin would be to a person, and yet, as Linn Shepherd explains, doctors are regularly prescribing doses of artificial oxytocin which are considerably higher than the licensed dose without attempting to discuss this with the pregnant woman or person that they are treating. Oxytocin is a hugely powerful hormone which demands respect in its quiet, shy way. Tracy Ripley champions the hormone, explaining some of its many influences over the body, and the 'use it or lose it' risk that we are potentially facing.

Gemma McKenzie looks back on the history of women and our medical treatment, how our hormones have been denigrated rather than respected, and she reflects on how this culture of disdain within medical circles continues to this day. What harm could be avoided if we have Continuity of Carer by midwives and doctors who understand and respect the hormones of birth? AIMS's campaign on Continuity of Carer continues, and we have published our campaign update here.

Speaking of continuity and care, there's a fascinating comparison between human birthing and that of one of the most valuable animals (in human monetary terms), horses. Katie Hickey, doula and vet, compares the care and respect given to a horse's birth physiology in comparison to that given to most humans.

When it comes to getting the care we want and need, it might be helpful to look at using some of the powerful techniques of mediation. While mediation is the use of a third party to help to reach a mutually agreeable conclusion, there are hints and tips which can be useful for discussing intervention options with doctors and midwives, which Paul

Golden, midwife and mediator, has shared with us in this Journal.

We are honoured to host an interview by Rachel Bolero with birthkeeper Kemi Johnson, independent midwife, hypnobirthing teacher and founder of the popular Facebook group, 'Induction of labour'. Kemi's work in supporting the rights of women and pregnant people is so desperately important and we thank her for sharing her story with us.

I would like to thank Nadia Higson, AIMS Trustee, for her report on her trip with our Chair of Trustees, Debbie Chippington Derrick, to the last ENCA meeting. We are excited to announce that AIMS will be hosting the 2020 ENCA meeting, right before our 60th birthday bash – do come and join us!

To round off this issue, we have some really useful book reviews thanks to our Book Reviews Editor, Jo Dagustun.

If you have a contribution to share with AIMS for the next Journal, do get in touch with me at journal@aims.org.uk.

Thank you so much, as always, to all our readers and supporters. The AIMS Journal is only possible thanks to our members, and buying a membership is a wonderful way to support AIMS's work. As we say, 'There for your mother, here for you, help us to be there for your daughters'.

* *This article was updated on 12/12/2019 to show that the word «hysterectomy» is linked to the entymology of the Greek word ‹hystera›, and we very much appreciate those who contacted us to ensure the accuracy of this piece.*

Article

Induction with synthetic oxytocin: less is more

By Linn Shepherd

Administration of synthetic oxytocin – induction of contractions

Synthetic oxytocin has been used since the 1950s for induction and augmentation of contractions. Induction and augmentation only differ in that induction is to try to start labour, whilst augmentation happens after contractions have started, to improve their strength or organisation, and make them more efficient.

In the UK, 'Syntocinon'[1] is the name that most people associate with synthetic oxytocin, but other companies now produce synthetic oxytocin under the simpler name 'Oxytocin'.

According to the approved instructions licensed for synthetic oxytocin for induction and augmentation of labour, the concentrate should always be a well-diluted solution for administration intravenously, and never administered undiluted, by intramuscular injection before the baby has been born.

When a woman has consented to intravenous synthetic oxytocin, the infusion (controlled by an electric pump) will be started:

- at least 6 hours after induction of labour with prostaglandins;
- after rupture of membranes (spontaneous or artificial) with a favourable cervix;
- before rupture of membranes with a favourable cervix;[2]
- to augment contractions (as described earlier).

Limitations set by the licensed instructions for synthetic oxytocin

The maximum dose of synthetic oxytocin to start an infusion when no contractions are present is 4 milliunits per minute (4 mU/min).

Increases of infusion rate can be made from 20 minutes after the previous increase, at no more than 2 mU/min more than the previous infusion rate. The licensed terms of use and guidance for managing synthetic oxytocin infusion should be applied in all cases aiming to reduce the rate slightly – if possible – once labour is established, to minimise the input of synthetic oxytocin in the presence of maternal oxytocin.

See Figure 1 below for an illustration of the dosages.

Good practice when using synthetic oxytocin

During augmentation of labour, it may be possible to start with less than 4 mU/min because maternal oxytocin is already at work. If the initial rate-per-minute of the intravenous infusion has not achieved the desired effect (about 3 contractions in 10 minutes), the dosage rate is speeded up *slightly*.

Fine-tuning with smaller increases of 0.5 mU/min or 1 mU/min can be tried first, to blend with maternal oxytocin. This is explained later.

Standard prescribing practices

If a doctor prescribes you medicine, the prescription relays instructions to the pharmacist, who checks the prescription, and provides the requested drugs clearly labelled with the name of the drug, your name, information about the dose and timings of the doses, and any warnings, such as 'Do not exceed stated dose'. If a pharmacist is concerned that a mistake has been made with a prescription, they have processes to follow to address this.

Doctors can prescribe drugs that are not licensed for pregnancy for the condition you have and at greater doses than are recommended, if the licensed dose has been ineffective. When prescribing a higher dose, they should explain their reasons during the discussion with you, and formally obtain your consent.

Current prescribing of synthetic oxytocin

Hospital doctors should also follow this standard of prescribing procedure for every use of synthetic oxytocin that does not adhere to the licensed instructions. But somehow synthetic oxytocin,[1] as it is currently being prescribed for during and after labour, is slipping through the 'consent' net. The RCOG's recommended regime ***advises*** dilutions, dosage steps and a final maximum that all rise well above the recommended and (therefore) licensed limitations and this is not being explained to women, and their consent is not being obtained.

If unlicensed dilutions are declined by women who wish to receive the licensed dilution with full dosage range and fine-tuning options (via volumetric pump), in hospitals where only syringe drivers are available, a drip infusion can be requested, as a midwife will (or should) be in attendance continuously.

See Figure 2 below, which is from Royal College of Obstetricians and Gynaecologists, called 'active management', first issued in 2001.[3, 4]

These RCOG guidelines suggest that after rupture of membranes (whether spontaneously or artificially), the infusion should be started at 1 mU/min, being raised to the licensed maximum (20 mU/min) by three hours later. In practice, contractions should start and settle[5] in the range from 4–12 mU/min.

The recognition of early disorganised contractions and their attempt to organise themselves is an important skill which midwives should develop to protect patients from receiving an unnecessarily high infusion rate, which risks desensitising oxytocin receptors, thus causing contractions to ease off. The midwife may mistakenly assume that a higher infusion rate is needed, but it would be better to reduce the infusion to the rate when contractions were last palpable, and wait a bit longer.

Always, infusion rates should be increased only according to the clinical need, to improve the contraction rate without losing complete relaxation for at least a minute between them. (The clock times on a table of infusion rates are a loose guide only.)

Consent and additional risk factors

This article highlights the need for doctors and prescribing midwives working in NHS hospitals to restore standard consent procedures to hospital practice for the RCOG's unlicensed synthetic oxytocin regimes, and to inform women of other choices open to them, such as the licensed dosage range.

The RCOG's unlicensed synthetic oxytocin regime comes with the National Institute for Health and Care Excellence's (NICE) recommendation for an epidural in advance, accepted by many women, and the loss of fine-tuning options, which increase the risk of overly-strong contractions, fetal distress, complicated births and postpartum haemorrhage.[6]

Providing this information, and seeking informed consent for unlicensed regimes, is not only the legal standard that women should expect from doctors registered to practise in the UK, but it protects non-prescribing practising midwives from seeking consent for unlicensed synthetic oxytocin regimes, for which they are not qualified or covered to take responsibility. It also protects prescribing midwives and doctors from potential allegations of assault for treatment carried out without informed consent, therefore finding themselves in conflict with the Montgomery ruling.[7]

Obtaining valid informed consent cannot be skipped over as too challenging or too time-consuming. The prescriber must have clinical reasons for going 'off licence' (as required by the RCOG's regime); must explain these to the woman; must warn her of the risks being added to her labour in so doing, also describing any benefits offsetting those risks; and must accept the woman's decision if she declines.

Regardless of what a woman has agreed to earlier in the labour or before labour, a doctor must request consent again following a full assessment of the patient, if they find what they consider to be an obstetric reason to prescribe over 20 mU/min (the licensed maximum). If the woman declines, 20 mU/min must not be exceeded. It is illegal for the doctor to proceed – as implied in many synthetic oxytocin policies – without formal consent.

In all cases, people can change their minds after consenting to any drug or procedure and it must be discontinued. It is illegal to start or continue a procedure or treatment for which consent has not been given, or after consent has been withdrawn.

Practical implications of the RCOG's regime

The RCOG regime increases the dosage range to 32 mU/min, as shown in Figure 2 below, 12 mU/min over the maximum licensed dose! The inflexibility of this regime, now used all across the UK, means that the optimum infusion rate for as natural a labour as possible may be missed for some women.

See Figure 3 below for the rates omitted by RCOG, and the unlicensed increments.

This regime is administered from a variety of unlicensed dilutions using volumetric pumps (or syringe drivers that offer 50 ml of intravenous solution at a time). For volumetric pumps, synthetic oxytocin is added to 500 ml suitable diluent, but the ability of volumetric pumps to provide an accurate dose is reduced when they are run at the slowest rates, as is required by the unlicensed dilutions recommended by the RCOG, of 10 IU or 30 IU in 500 ml.

The licensed 5 IU in 500 ml facilitates the full dosage range in a greater volume of fluid which can be administered more accurately via volumetric infusion pump.

The unlicensed increments of the RCOG's regime (after 4 mU/min) reduce the likelihood of successfully fine-tuning the infusion with maternal oxytocin, as only when changes of 0.5 mU/min are available (an option in the licensed instructions) can fine-tuning be achieved. While this situation persists with the RCOG's regime, so does the likelihood of partially desensitising oxytocin receptors.[8]

When using syringe drivers to administer the infusion, it has been common for trusts to permit 10 IU in 50 ml (twenty times stronger than the licensed dilution) so that 50 ml lasts longer. The syringe driver is more efficient than a volumetric pump, and fine-tuning is possible (although not being practised) but ***the bolus option should be disabled*** before a synthetic oxytocin infusion is started, because 0.5 ml of 200 mU/ml would risk fetal or maternal distress if accidentally infused.

Some trusts use weaker dilutions in their syringes but none uses the licensed dilution.

In other words, the full range of licensed options has not been transferred into the RCOG's regime. Currently, no in-between rates are supplied for midwives to even try fine-tuning (see Figure 2 below). The clinical effects of not being able to control a synthetic oxytocin infusion optimally, within the recommended dosage range as licensed, include contractions coming too often and/or lasting too long and/or allowing too little relaxation between, such that the biochemistry of normal contractions gets progressively out of sync risking an increase in fetal distress, that may lead to caesarean section in first stage or instrumental delivery at the end of second stage, and also postpartum haemorrhage after third stage. All of which may impact the baby and will certainly impact the mother, both during this birth and in subsequent pregnancies and births.

Importantly, the dilutions being used to facilitate the RCOG's regime should be deemed pharmacological because they function as a drug, instead of blending with maternal oxytocin physiologically, as the licensed dilution can achieve. Theobald (1965) stated, 'it has never been shown that the pharmacological drip is more effective than the physiological one, and it is certainly less safe'.[9] (A half-strength physiological dilution can also be therapeutically effective.[10])

Synthetic oxytocin and other effects on blood pressure

Physiological dilutions of synthetic oxytocin normally reduce blood pressure slightly, but pharmacological dilutions more-so.

When the latter also require epidural for relief of otherwise shock-inducing pain, blood pressure also falls due to the epidural. The natural response to shock is also lowered blood pressure to facilitate oxygenation of distressed tissues.

The overworking of the uterine muscle stimulated to contract by synthetic oxytocin over a period of hours, and sometimes without sufficient time to recover between contractions, produces acidosis which naturally leads to vasodilation – yet another blood-pressure-lowering effect. Acidosis also affects the unborn baby.

If oxytocin receptors are desensitised *as well*, their part in achieving vascular and muscular tone when it is needed at the end of labour is diminished or removed. Brindsden and Clark (1978) discuss this in their research report on postpartum haemorrhage following their trial with experimentally large increments of synthetic oxytocin.[11]

These five factors make a major contribution to excessive bleeding after birth, which could be prevented by using so little synthetic oxytocin that maternal oxytocin controls postpartum bleeding in the same way as after a spontaneous labour.

Is a shorter labour actually a benefit?

It is common for the term 'shorter labour' to be touted as a benefit of the use of synthetic oxytocin. But, even if the length of labour is actually being reduced on average, are individual women actually benefitting from this? Length of labour for an individual cannot be known beforehand, so determining whether an individual's labour has or has not been shortened by the 'active management' of their labour is not possible. So justifying high doses of synthetic oxytocin for this reason does not make sense.

Do epidurals mean the increased pain of induced labour is not an issue?

Giving an epidural that successfully obliterates the pain generated by higher-than-necessary doses of synthetic oxytocin might address the issue of the pain, but it does not overcome the other potential risks from the use of unlicensed synthetic oxytocin, and an epidural itself introduces new risks.

Care of women during induction of labour

When a woman agrees to prostaglandins treatment, or a synthetic oxytocin infusion, it is important that midwives recognise her status as a patient undergoing treatment, with new care needs which are more complex than the natural biochemical interactions of spontaneous labour.

This is because the synthetic oxytocin infusion requires continuous supervision by a qualified professional, and as many fine adjustments as necessary, according to its effect on the woman, the baby's tolerance of it, and to ensure every relaxation between contractions lasts for one whole minute or more. Therefore, the woman can never be left on her own with the infusion still running. This is clearly stated in the instructions, and underlined by advice from the World Health Organisation.[12]

If the midwife has to leave the woman, then the synthetic oxytocin infusion should be paused, and this should be recorded in the notes and on the cardiotocography (CTG) trace. After the midwife returns, she should count the fetal heart with a Pinard's stethoscope to check that it is still in the normal range and reassess the contractions for 10 minutes. If all other observations are normal (and recorded), the infusion can be restarted at a slightly lower rate than when it was paused. These details must also be recorded in the notes.

Finishing labour after physiological dilutions of synthetic oxytocin

Once labour is established, the infusion can often be slightly reduced. An additional benefit of fine-tuning synthetic oxytocin is that, as far as possible, the rest of labour proceeds under the influence of maternal oxytocin with no further infusion rate increases.

During second stage, as expulsive contractions begin, maternal oxytocin rises significantly,[13] allowing for synthetic oxytocin to be stepped down and discontinued within the hour before the baby is born.

When this handover between synthetic oxytocin and physiological labour is conducted with skill during second stage, after third stage (birth of the placenta) natural oxytocin normally achieves a sustained, spontaneous contraction that prevents excessive postpartum bleeding. Traditionally, a midwife stays another whole hour to check regularly that the womb is well-contracted, or bleeding is well-managed.

Restoring choice to clinicians and women

Nearly-natural labours are well within reach when the synthetic oxytocin infusion is managed according to the licensed instructions. Reinstating them formally is an essential consideration for Trusts, both from a safety and a legal perspective, as the standard licensed dilution is strong enough for its role to enhance sluggish contractions, without desensitising oxytocin receptors.

Remembering the baby

The baby should not be accepted as 'the canary in the mine' to indicate when something is wrong, rather than eliminating predictable causes of fetal distress beforehand.[14] The ability to fine-tune synthetic oxytocin during labour is the most accessible way to prevent fetal distress during induced and augmented labour, or to address it immediately by slowing or discontinuing the infusion. It should be noted that fetal distress can occur for other reasons when synthetic oxytocin is not in use, which is why fetal distress when sythetic oxytocin is in use, must immediately be taken seriously.

Summary

Consent from the woman for synthetic oxytocin infusion must always be sought, but currently no-one is informing women that when synthetic oxytocin is recommended, it is likely to be prescribed and administered in unlicensed dilutions and increments, with regular disregard for the benefits and safety measures built into the licensed instructions.

Restoring fully informed consent procedures, and the licensed dosage range as a valid option to be selected by women, doctors and midwives for a myriad of clinical reasons – and a natural maternal desire for as normal an outcome of labour as possible – promotes far better outcomes for women and babies, and higher professional satisfaction.

Illustrative tables

The following tables may be useful to give to your midwife or doctor to illustrate the figures and calculations in this article. In the Key and charts, 1 International Unit (IU) = 1000 milliunits (mU).

Figure 1 – Infusion Options in the Licensed Dosage Range

KEY to synthetic oxytocin drip infusion and for volumetric pump

In the table below **drops** match **mU location** and **ml location**.

Numbers in bold have no additional therapeutic meaning.

	milliunits (mU) / minute				Volume (ml) / minute			
A	**0.5**	1	1.5	2	**0.05**	0.1	0.15	0.2
B	10.5	11	11.5	12	1.05	1.1	1.15	1.2
	18.5	19	19.5	**20**	1.85	1.9	1.95	**2.0**

Rate changes of 0.5 mU / minute x 20 minutes = 10 mU (more, or less)

NOTE: volume variations will depend on the dilution being infused.

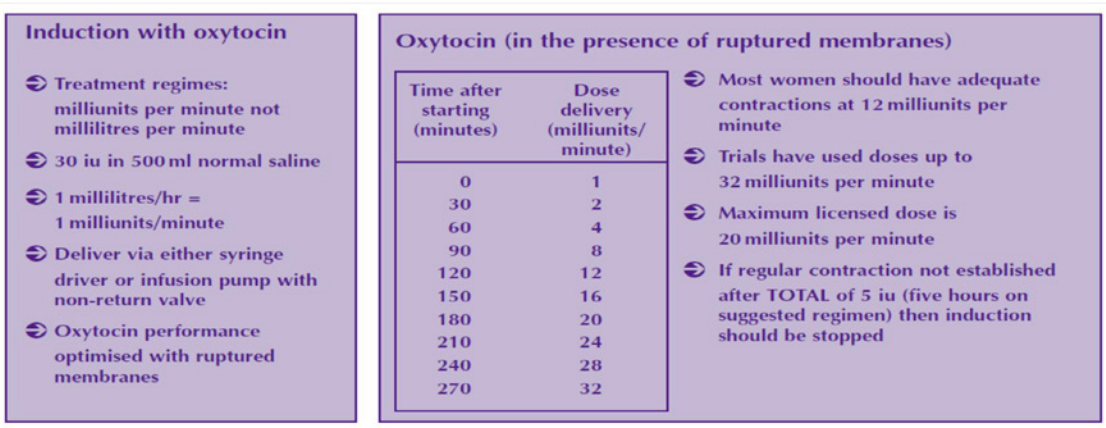
5 IU synthetic oxytocin in 500 ml diluent **for drip infusion** (10 mU / ml)												
	0.5 mU / drop				Total mU / no of drops				Volume (0.05 ml / drop)			
A	1	2	3	4	0.5	1	1.5	2	0.05	0.1	0.15	0.2
	5	6	7	8	**2.5**	3	3.5	4	**0.25**	0.3	0.35	0.4
	9	**10**	11	12	4.5	**5**	5.5	6	0.45	**0.5**	0.55	0.6
	13	14	**15**	16	6.5	7	**7.5**	8	0.65	0.7	**0.75**	0.8
	17	18	19	**20**	8.5	9	9.5	**10**	0.85	0.9	0.95	**1.0**
B	21	22	23	24	10.5	11	11.5	12	1.05	1.1	1.15	1.2
	25	26	27	28	**12.5**	13	13.5	14	**1.25**	1.3	1.35	1.4
	29	**30**	31	32	14.5	**15**	15.5	16	1.45	**1.5**	1.55	1.6
	33	34	**35**	36	16.5	17	**17.5**	18	1.65	1.7	**1.75**	1.8
	37	38	39	**40**	18.5	19	19.5	**20**	1.85	1.9	1.95	**2.0**

Licensed dilution in mU, in drops / minute, mU/drop and millilitres (ml).
A 1 drop - 20 drops / minute **B** 21 drops - 40 drops / minute

Volumetric pump: 20 minute settings - dose / minute & volume												
	mU / minute				mU / 20 minutes				ml / 20 minutes			
A	0.5	1	1.5	2	10	20	30	40	1	2	3	4
	2.5	3	3.5	4	**50**	60	70	80	**5**	6	7	8
	4.5	**5**	5.5	6	90	**100**	110	120	9	**10**	11	12
	6.5	7	**7.5**	8	130	140	**150**	160	13	14	**15**	16
	8.5	9	9.5	**10**	170	180	190	**200**	17	18	19	**20**
B	10.5	11	11.5	12	210	220	230	240	21	22	23	24
	12.5	13	13.5	14	**250**	260	270	280	**25**	26	27	28
	14.5	**15**	15.5	16	290	**300**	310	320	29	**30**	31	32
	16.5	17	**17.5**	18	330	340	**350**	360	33	34	**35**	36
	18.5	19	19.5	**20**	370	380	390	**400**	37	38	39	**40**

A Start rates for augmentation. Maximum start for induction = 4 mU / minute
B upper range to maximum 20 mU / minute. Need formal Consent to exceed.

Figure 2 – RCOG guidance table (2001)



Induction with oxytocin

- Treatment regimes: milliunits per minute not millilitres per minute
- 30 iu in 500 ml normal saline
- 1 millilitres/hr = 1 milliunits/minute
- Deliver via either syringe driver or infusion pump with non-return valve
- Oxytocin performance optimised with ruptured membranes

Oxytocin (in the presence of ruptured membranes)

Time after starting (minutes)	Dose delivery (milliunits/ minute)
0	1
30	2
60	4
90	8
120	12
150	16
180	20
210	24
240	28
270	32

- Most women should have adequate contractions at 12 milliunits per minute
- Trials have used doses up to 32 milliunits per minute
- Maximum licensed dose is 20 milliunits per minute
- If regular contraction not established after TOTAL of 5 iu (five hours on suggested regimen) then induction should be stopped

Figure 3 – Full Licensed Dosage Options Modified and Extended by the RCOG (2001, 2008)

5 IU synthetic oxytocin in 500 ml

Full licensed dosage range: mU / minute

0.5	1	1.5	2	2.5	3	3.5	4
4.5	5	5.5	6	6.5	7	7.5	8
8.5	9	9.5	10	10.5	11	11.5	12
12.5	13	13.5	14	14.5	15	15.5	16
16.5	17	17.5	18	18.5	19	19.5	20

Maximum licensed rate = 20 mU / min

24

28

32

Highlighted RCOG regime showing rates omitted by it and unlicensed increments 4 to 8 to 12 to 16 to 20 to 24 to 28 to 32 (mU).

Linn Shepherd is a retired nurse-midwife from Scotland, who practised midwifery in Scotland and England until leaving to raise her children. She has investigated the early research that underpins the instructions licensed for intravenous infusions of synthetic oxytocin, for outcomes of enhanced obstetric labour comparable to those of spontaneous labour.

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[Dosage tables courtesy of www.oxytocinmeasures.com Other info is at: GMC website, NMC website, www.birthrights.org.uk]

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Article

Oxytocin: Love, Birth and Bulldogs

By Tracy Ripley

Often, our hormones are viewed as a torment, they shoulder the blame for mood swings, irritability, aggression, forgetfulness, anxiety, weight gain and a host of other issues. It would seem that the more affluent and advanced the culture, the more our hormones are viewed as an interference, particularly where work and productivity may be hampered by our errant bio-chemical messengers. Historically women have been censured for hormonal hysteria, the medical profession were on hand to mollify the middle and upper classes with various tonics and bed rest, however working class women, who couldn't afford large medical bills, did not appear to suffer in quite the same way but were just as likely to encounter fear and ignorance around 'women's problems'. Unfortunately in the worst case scenarios women suffered incarceration and even surgical procedures such as hysterectomy (removal of the uterus) to treat female hysteria, to aid recovery from their hormonal maladies.[1]

More recently, our hormones, in particular oxytocin, have been subject to investigation and studies which have quadrupled in number in the last decade.

Pregnancy and birth create the foundation of all human relationships and connectedness. Oxytocin is no lone wolf, it works closely with other hormonal peptides and neuro-transmitters to bring about the necessary changes to facilitate successful reproduction[2,3] and for the propagation of our species.

For millennia, *Homo Sapiens* were, and still are, dependent on cohesive social groups to function and survive in hostile environments, we learn whom we can trust and whom we cannot and our neural pathways serve to remind us of potential dangers and what makes us feel safe. Our hormones are responsible for our version of reality and how we behave in that reality.[3, 4]

Oxytocin – the name is derived from Greek, meaning rapid-birth[5] – is believed to have been around as long as the mammals it serves, approximately 100 million years.

Oxytocin is produced in the posterior pituitary gland along with vasopressin and is derived from Latin meaning *Vessel Pressure*.[5] Oxytocin and vasopressin are produced and work together and both have several essential jobs maintaining homeostasis. Homeostasis is our body's way of maintaining equilibrium and applies to all of our anatomical systems.

The ways that both oxytocin and vasopressin work are both capable of being epigenetically altered through human experiences and interactions. Both influence adaptations and behavioural responses to external stimuli and 'cement' good or bad experiences into our psyche. Experiences in utero, and, critically, in the 1001 days after birth, develop our neural pathways and impact on us into adulthood.[3, 6, 8]

Oxytocin is released during pregnancy in pulses via the cardio-vascular system and also in the maternal brain. The pulses become longer, stronger and increasingly frequent towards the last few weeks of pregnancy. In addition, the amount of oxytocin receptors found in the smooth muscular tissue of the uterus rise exponentially from the second (11 f mol/mgDNA) to the third trimester (1140 f mol/mg DNA) and increase in labour to 3550 fmol/mg DNA.[3] Although it is not yet confirmed what specifically triggers labour, it is known that a number of hormonal changes occur simultaneously in baby and mother. Melatonin, a hormone released to aid sleep and circadian rhythms (sleep and wakefulness programming), appears to stimulate oxytocin production as well as prolactin, which works with oxytocin to provide breastmilk. Prolactin, which drives 'nesting' instincts, triples in production from approximately 38 to 41 weeks.[3, 8]

Oxytocin receptors in the uterus are primed for the interplay of hormones that initiate labour, oestrogen levels

begin to rise and in turn stimulate prostaglandins softening the cervix in preparation for dilatation and progesterone levels begin to fall. Progesterone has secured the foetus within the uterus throughout pregnancy, and as birth approaches the uterus must change its composition and function to allow the baby to pass through the cervix and into the birth canal. Oxytocin receptors recognise increasing maternal oxytocin levels in the blood stream, a 'lock and key' mechanism ensures that oxytocin and oxytocin receptors bind together to act on the powerful uterine muscle. Hormonal communication initiates a positive feedback loop that will not end until the baby is born.[3, 8]

The many hormones of birth

Hormones which inhibit the action of oxytocin are our 'flight or fight' hormones: Adrenaline, cortisol and catecholamines. However, they also have vital roles in the birth journey, such as helping the baby's lungs to mature, protecting the baby's brain from hypoxia during birth and promoting alertness of the newborn for eye contact and bonding after birth. These hormones can co-exist and function together with oxytocin, but if perceived threat or fear take over, oxytocin beats a hasty retreat. It is often noted that women who no longer feel safe in labour will experience diminishing contractions as result of the reduction of oxytocin circulating in the blood stream.[2, 3, 8] For some women, just leaving their home or arriving at hospital is enough to stop contractions.

Endogenous oxytocin (that is, oxytocin made within our body) is released in pulses at around three in every ten minutes, usually coinciding with the frequency of surges in an active labour. However recent research indicates that there is a possibility that other hormones also have a role in labour surges as pulses may not necessarily coincide with surges.[8] Oxytocin pulses peak at the moment of birth and when the placenta is expelled. Oxytocin is an effective endogenous uterotonic (helps the uterus to contract effectively) and prevents sustained and heavy blood loss, particularly if the mother has experienced a physiological birth or one with minimal intervention.[3, 6, 8]

If the mother is truly undisturbed, with skin to skin and eye to eye contact with her newborn, a series of biological, emotional and behavioural events are likely to take place.[2] The mother will want to hold her baby close and may be overwhelmed with feelings of love and euphoria. Endorphins are triggered by the sensations of labour and alleviate discomfort. Dopamine (reward and motivation) and serotonin (belonging and happiness) are circulating to adapt maternal feelings and behaviours to care for and be near to her baby.[2, 6]

Vasopressin influences protective and defensive behaviours of those who are bonded socially, in addition to maintaining blood pressure. Oxytocin gives way to vasopressin when there is a perceived or real threat – to give an example of a You Tube video that went viral, 'The Battle at Kruger' demonstrates this mammalian behaviour perfectly, a buffalo calf faces certain death as it is encircled and attacked by lions. The maternal bond in this case defied almost certain death, and once the danger is over, oxytocin returns and mother and calf stay close. Transposing this example of the mother-baby bond and protection to a woman and her newborn, interference during this crucial process is something that could seriously impact this vital bond and should therefore be avoided in any situation other than a medical emergency.

Oxytocin is a mild amnesiac, and women and birth workers will recognise how quickly after the birth the woman will forget her discomfort and doubts experienced during labour when she holds her baby for the first time!

The mother will be focused on her baby picking up on non-verbal cues and cries becoming 'tuned in'. Indeed 'baby brain' is no misnomer, it is a primal function to ensure protection and survival, the mother subconsciously bypasses insignificant stimulus, instead, concentrating on the physical and emotional needs of her new-born.[10]

Oxytocin and prolactin play a central role in the production of breastmilk. Mother and baby working in tandem to create the optimal behavioural prompts and the appropriate hormonal responses to provide nutrition that is adaptable to her baby's changing requirements.[2, 3, 6, 8]

Oxytocin has a direct influence on positive maternal behaviours. The formation of secure attachments governs a future blueprint, impacting on both mother and baby, determining their ability to cope with stressful and novel situations. Conversely, its absence may have medium and long term negative effects on the mental and emotional health of both mother and baby.[6] Could this have implications in the rising numbers of reported maternal

mental health problems which are now recognised as a major public health issue, with a long term cost to society of £8.1 billion for each annual group of births in the U.K.?[11]

Interestingly, Oxytocin is present in significant levels of those who are in proximity during birth or shortly afterwards. Skin to skin contact between the baby and the mother's birth partners initiates oxytocin release and creates new neurological pathways, strengthening bonding and promoting caring behaviours. Grandparents and other family members can be under the influence of oxytocin, prompting adaptive behaviours that protect and nurture the whole family dynamic and serve to promote various physical and emotional health benefits throughout the ageing process.[12] In a much wider social context, oxytocin promotes characteristics such as empathy, generosity, altruism, trustfulness and trustworthiness. Currently, Neuro Economists are studying the role of oxytocin and its applications in the world of politics, industry and commerce.[13]

Oxytocin and Induction

Endogenous oxytocin has a plethora of holistic health and well-being benefits for mothers, babies and our wider social relationships, yet in current maternity systems the support needed to encourage our endogenous hormones to flourish appears to be overlooked in favour of the use of synthetic oxytocin and other medical interventions.[3, 14] Given our knowledge of the importance of our natural hormonal systems, what inadvertent harm are we causing women and their babies when we intervene unnecessarily in birth?

In the U.K., inductions of labour have increased to 33% (2018/2019) from 20.4 % (2007/8).[15] Some women, or their babies, may benefit from induction of labour however *all* women who are exposed to this intervention are at higher risk of the negative effects of synthetic oxytocin and other interventions that may follow. Worsening maternal mental health and depression within the first year of birth increases by 32% (an additional 2 in every 100 woman) compared to those who were not exposed to synthetic oxytocin, despite no previous history of depressive symptoms.[16] Suboptimal mother-baby bonding, feeding issues and the preparedness of the baby to be born are just some of the other concerns.[3, 17] With many women reporting coercive and negative language used by clinicians to persuade or even bully women into interventions,[18] it is no wonder that women have diminishing faith in their own bodies' ability to birth without interventions.[19] A recent perspective in the BJOG has put forward the case for all women to be induced at term,[20] however this medicalised point of view has been challenged with evidence that women who have continuous support in labour are less likely to have interventions and are more likely to report a positive birth experience.

Michel Odent has spoken about the case of bulldogs. Because of a desire to genetically alter the bulldogs' physiology and produce a large head, required by breed standards, vaginal birth became problematic, often resulting in death of the pups and the mother through dystocia. Veterinary assistance helped with artificial insemination and caesarean sections to decrease mortality rates. As dogs are able to reproduce quickly, the longitudinal effects of this intervention have become apparent, bulldog mothers have largely become incapable of giving birth without veterinary assistance by caesarean section. It seems intervention and the inevitable manipulation of hormones has decreased the presence of oxytocin and oxytocin receptors in female bulldogs. But, interruption of Oxytocin functionality may disturb more than physiological systems. According to a longitudinal study between 1979 and 2009, *Psychology* graduates in the United States were found to be 40% less empathic than participants studied just a few decades ago.[21] While we don't have the evidence to say that this is caused by the increase in induction, enough is now known about these essential complex hormonal systems to understand that unnecessary hindrance could have unpredictable consequences for future generations.[2, 6]

Oxytocin: Use it or Lose it

The phrase 'use it or lose it' comes to mind when exploring the debate for safely promoting the physiology of childbirth and protecting our endogenous hormones, the same ones that have precipitated our evolution and protected us as a race for millennia. These hormones deserve recognition and respect. They are becoming vulnerable in the face of increasing interventions and medicalisation of birth. Awareness of the importance and complexity of our hormonal systems is continuously growing through the wonderful dedication of researchers and authors referenced in this article. Pregnant and birthing women need accessible

information on their hormonal alchemy, these complex hormonal helpers have surprisingly simple and inexpensive requirements to perform their valuable work during birth: a space that feels safe to the birthing woman, and birth attendants who she knows and trusts.

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Article

Do animals need doulas?

By Katie Hickey

Before I became a doula, I was a practising veterinary surgeon. I've had medical doctors joke with me about my change in career and ask if I will specialise as a 'doula for animals'. To which I always reply, with a smile on my face, 'No, because animals are not interfered with unnecessarily like humans are'.

I have worked in many different fields within veterinary medicine over the past 10 years and it was my love of horses that spurred me to pursue life as a vet (pun intended). It is interesting to explore the differences in the way we treat humans during the birth process compared to animals. I have chosen horses in particular for the sake of this article for several reasons; I have experience working with them as a vet and they are incredibly valuable animals.

Racehorses are often worth tens of millions of dollars, it's BIG business. The most expensive racehorse sold for breeding purposes is reported to have cost $70 million. The breeding of horses, particularly for racing, is a highly specialised area, and it's taken extremely seriously by owners, care givers and veterinarians alike. Horse owners and managers are given recommendations for how to care for mares during pregnancy and foaling (giving birth) as when things go wrong there are often very serious consequences and potentially huge financial implications.

Many of you will be familiar with the commonly used analogy during antenatal classes about how animals give birth. It is often discussed especially in terms of the natural physiology of birth, the hormones that are involved and how you can create a supportive environment to help encourage our natural hormones and therefore the natural birthing process.

For animals in captivity, including horses, the emphasis is to avoid disturbing them at all costs. Horse owners often feel the temptation to rush in and lend a helping hand. It is hard to resist feeling as though you are part of this miracle of nature. 95% of mares will foal with no complications and require no assistance at all.1 Intervening during a normal foaling can do more harm than good; mares will often stop straining and walk off if disturbed. This could delay the foaling process and put the foal's life at risk.

Most mares will foal at night and prefer, if not require, a quiet, dark place to foal without disruptions. Even though it is advised by most veterinarians to keep a frequent watch on mares approaching the foaling time, disruptions can delay the onset of this stage of labour. There are CCTV-type camera systems that can be purchased to help keep a watchful eye on the mares but from a distance so as not to cause interference of any sort. Any type of 'watching system' that helps support a quiet, dark, uninterrupted environment will help the mare.

Niles Newton documents the response of labouring mice to fear and stress. She discovered that, "*When the mice were disturbed, especially by a lack of privacy, catecholamine surges shut down early labour. Later in labour, hormone release was inhibited and the fetal-ejection reflex did not occur (Newton, 1987; Newton, Foshee and Newton, 1966). In both instances, nature responded to threats, potential or real, in the birth environment and protected the mother and her young.*

Newton went on to describe the similarities in the hormonal orchestration of making love, giving birth, and breastfeeding. In each, hormones facilitate the process – indeed, are integral to it – and all are easily disturbed."[2]

Why is it, then, that our current birthing system seems to be working at complete loggerheads with what we know and understand about the natural physiology of birth? Could our current birth system be to blame for our high rates of intervention during childbirth?

Dystocia is when birth is difficult and/or slow and can be caused by multiple different factors. It can occur in the active first stage or in the second stage of labour. The frequency of dystocia in humans is reported with a large range and affects approximately 21–37% of first-time mothers and 2–10% of mothers who have given birth before.[3] The incidence of dystocia in horses is reported to be 4–10%.[4]

You might be wondering what the incidence of dystocia would be in humans if our birth environment was focussed on being a quiet, dark and uninterrupted safe space, much like for our horse companions? We can look at Ina May Gaskin's statistics from her aptly named birth centre, 'The Farm', and we see that 94.7% of births are completed at home and they have a 1.7% caesarean birth rate,[5] compared to the UK national statistics where over a quarter of all births end in caesarean section.[6] The most common reason for performing an emergency caesarean is – you've guessed it –'failure to progress', another way of describing dystocia.

There are several comedy video sketches that explore what would happen if we were expected to have sex, or go to the toilet, under the same conditions that we are expected to give birth in;[7] I encourage you to have a look! There's also the AIMS book, *The Princess and the Poo,* which explores the birthing environment and how it affects labour.[8] [9]

So, whilst I very much enjoy my work as a doula, I would much rather that in the human birth world there was no need for doulas to help protect the sacred private space around birth. I would go as far as to say that having a doula present at birth in UK hospitals to me sometimes feels like closing the stable door after the horse has bolted, as we are somewhat powerless against the enormous birth machine that has been created.

Given the current environment that most people give birth in – in hospitals, with bright lights, continuous electronic monitoring, frequent disturbances, multiple strangers present in the room and the constant threat of intervention – it's a miracle that anyone is able to give birth at all! It is certainly not surprising that our current rates of dystocia and intervention far exceed those seen in the horse world.

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Article

Resolving conflict around childbirth choices

By Paul Golden

Respecting birthing women's rights

The law requires that birthing women and their families have their childbirth choices respected. Instead, they face challenging times. They experience conflict arising between their choices and the hospital. There are conflicts between guidelines and women's wishes. Resolution to these conflicts can come from communication tools such as mediation-style communication. This article aims to provide women and families with some tools to help prevent and resolve conflict by using effective mediation communication techniques.

Mediation usually involves a third party who uses their communication skills to support people in reaching resolution. The mediator uses techniques that encourage communication and negotiation. However, these skills can be used without a third party to encourage positive, empathic communication. This can be by the woman herself in her interaction with maternity service staff, or by her partner, doula, midwife (employed or independent) or other supporter.

The informed consent and refusal process must include the freedom to consent to, or refuse, any and all treatments, including those that might be seen as life saving for the mother or baby. UK law protects the autonomy of the woman's right to choose what she does with her body. In the UK Supreme Court case of Montgomery v Lanarkshire in 2015,[1] Lady Hale stated:

> *'Gone are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.'*

The summary of the case is that women have the right to be told information relevant to them. This ensures that they can make an informed decision. However, the way this has been interpreted by some clinicians is to use fear (and sometimes coercion) by telling the woman in an unbalanced way how she is putting her baby at risk. This is incorrectly seen as meeting the legal requirements to warn of all *material risks*, however slight. Responsibility for decisions needs to be held in partnership between women and staff with balanced, evidence-based information and respectful communication, and with the final decision itself being one that only the woman herself can make. By using some basic mediation skills, women and families can take more control of this process.

What is mediation?

'Conflict is opportunity' (Einstein)

Everyone is a mediator, a peacemaker. We behave as one naturally at home with our loved ones. When we fight in the morning, we make up by the evening. We listen, we allow others to express themselves so they will listen to us. We may feel better for venting. We find common goals by reframing what we are fighting about. There can be win-win solutions.

What if we are outraged by hospital rules, or feeling emotional? Maybe we think someone else would be better at mediating. In that case, use a third party if possible. This might be your partner, friend, family member or doula, and some consultant

midwives or independent midwives can take this role – and you can always consider a professional mediator. However, all of us can mediate when there is only us to sort it out.

Create a framework for any hospital meeting, including being prepared for the unexpected. Consider using role play; perhaps video it on your phone, or rehearse in front of the mirror for any planned conversations about your wishes. This 'training' allows us to be flexible, assertive and clear. We may still *react* but we can pause and take a moment – even one breath – and then ***respond***. This response, rather than reacting, will be more productive. We are mediating ourselves. We can *fake it* until we *make it* with calmness. The calmer we are, with inner confidence, the greater the influence on others around us. If we lose the calmness, we can walk away and either return later or get a third person to help.

We can control how we act ourselves, and we can possibly influence others, but we are not responsible for their actions. Using mediation communication ideas does not make women responsible for the way that the healthcare provider responds to them, but it might make the discussion more positive and may lead to a better outcome for all.

Mediation is:

- **Listening** and being listened to (venting and expressing safely).
- **Empathetic** questioning, with a genuinely caring attitude in voice and body language. Why? What? When? How? Who? Where? How are you? What would you like?
- Then **compassionately questioning** the answers. What would it take for you to agree – e.g. leaving the cord to continue pulsating for 30 seconds? For 30 minutes? Or a positive assertive statement would be, 'I will let you know when you can cut the cord'.[2]
- **Creating momentum** by getting small agreements leading to larger agreements.
- **Responding** rather than reacting.
- **Connecting** to calmness and inner confidence through breath and mindfulness training.
- **Reflecting** on what is learned in each conflict, breaking the patterns of habit with awareness.

The key questions are, 'What would you like?' and 'How are you?'. This genuinely empathetic questioning creates momentum from conflict to resolution through being cared about. We all wish to love and be loved. It is as fundamental as that. It is really important to understand where the other person's position comes from, to respect that – but also to remember that their position, the issues that worry them, are *their* problem, not ones we need to take on. Understanding the pressures on the healthcare staff (e.g. concerns about being sued, pressure from management to get babies out and clear beds, pressures from the various 'care bundles', and so on) can help us to understand *why* they are saying what they say. This can help us to formulate a response that recognises their position, and when we show respect for the other person's needs they are less likely to fight with us. Show that we are listening to them. Model and mirror positive behaviour – listening to someone helps them, in turn, to listen to us. An example of this might be:

Hospital doctor: 'You can't go home. Your baby needs close observations of his sugars as he's so small. He's at risk.'

Mother: 'I don't need permission from you. I do need support and evidence-based information.' She starts packing her bag, then, remembering mediation ideas, she says to the doctor, 'What would you like?'.

By then listening to the reply, the mother shows that she is agreeing to engage with the doctor, which opens the door to a possible agreement.

Hospital doctor: 'To monitor his blood sugars and ensure he's feeding enough and warm enough and to protect him from infection.'

Mother: 'Okay, what if … I will feed him at least every three hours and more if he asks, and we observe him. We can have the midwife visit, and take advice over whether a blood sugar test is required or not.'

Hospital doctor: 'I'd prefer you both to stay. … But I can see that this is what you want so we can work with this.'

Mother: 'Okay. I'm going home with my baby now.'

Afterwards, we hope that the doctor will reflect on the conversation and realise that they pushed the mother and could use better communication next time. The mother was angrily asserting her rights, but then she adopted a middle-path mediation communication style to listen to the perceived needs of the hospital and, by engaging, reached some agreement. The hospital had the choice of working with the woman or threatening to call children's services. That would escalate matters. Both parties saw the benefit to the mother and baby of de-escalation. Now the mother agreed to allow a midwife to visit and support her with her baby at home on her terms. Whether this is called assertive advocacy or mediation doesn't matter. It is effective communication, including respectful listening, and agreement to discuss the issues even where that is only partial agreement.

When time is limited, we can focus on what we want rather than what we do not want. For example, if a long, possibly patronising explanation is being given to a woman about the risks she poses to her baby by ignoring hospital advice and guidelines, she can say: 'I don't need to hear more about that at the moment. I do need to focus on what I would like and how we can achieve this.'

Getting into arguments is unnecessary in many situations. Keeping to simple, open questions may be more likely to bring greater clarity. However much we mediate, sometimes we will not come to an agreement, and that is okay. The benefits of communicating are that this can continue to be built upon with greater trust later. Sometimes no words are required. Simply taking action can be all that's necessary, such as leaving the hospital when you are told you must stay for a certain check. The staff are frequently stressed and afraid of various responsibilities (real and imagined). The language of hospital staff can sometimes be overly threatening and it can feel like they have all the power. ***Taking action is a great power balancer.*** The beliefs people have about their power is a power itself; therefore the ability to change that perception is also a source of power.

There may need to be some negotiated give and take. How you get what you want may depend on what you are prepared to give. *This does not mean* that you have to agree to an intervention in order to get what you want (for instance, you don't need to agree to blood tests to be supported in a home birth). Rights are not up for negotiation in that way. Instead, try to work out where you can find agreement. That said, there are many situations where no negotiation is necessary, and a simple 'No' is required. When we avoid saying no, our bodies pay the price.

While it can be tempting to share the detailed information you may have researched, often situations around pregnancy and birth are charged with emotions, making it potentially upsetting to debate the merits of research. Having said that, sometimes bringing out a copy of the WHO, NICE or local trust guideline that contradicts the advice a midwife or doctor is giving might be helpful. For instance, my experience is that providing a NICE guideline stating that ultrasound scans are not required in a particular case has helped some clinicians to relax their insistence on scans.

The reports I have seen[3,4] about culture and hierarchy leading to bullying and clinical failings suggest a system that is slow to change. It is therefore imperative that parents challenge their caregivers to provide evidence, clear rationales and *evidence* for any intervention, including the possible risks and alternatives. Hopefully the skills shared above will help parents to do this in a way that is beneficial to them – although again remembering that healthcare practitioners are fully responsible for their actions, and if they are unkind, or if they do not engage appropriately with parents, that is solely their responsibility. They are then answerable to their regulators (GMC or NMC) and/or employers.

NHS and independent mediation services

Some hospitals are engaging with mediators. St Thomas' Hospital London, for instance, has a mediation service to help parents and staff. The mediator can 'shuttle' between parties, which is useful for saving face in certain cases where parties prefer not to see each other.

The role of the midwife as an advocate (UK NMC Code 3.4) can be compromised by defensive midwifery practice focused on the midwife keeping their job; however, NMC Code 4.1 states that midwives should '*balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment*'.

Doulas are often in a wonderful position with the opportunity to liaise or *mediate* with staff. Simply being there with calm confidence can have a positive ripple effect. The hospital staff have another pair of eyes shining a light on how they practise. A raised eyebrow, a tilting of the head, any useful compassionate engagement can get the staff to reconsider the true necessity of an action.

Birth Afterthoughts services

Some hospitals have Birth Afterthoughts services, which aim to help women to understand why certain things happened. These services can be valuable to women in helping them to understand what happened in their birth, and, done well, with good mediation skills, can be a helpful communication process. Some NHS trusts use PALS or Afterthoughts to protect them from litigation rather than resolve issues. The Parliamentary and Health Service Ombudsman[5] is a useful way to record and escalate unresolved NHS complaints.

NHS Resolutions

NHS Resolutions is the new name for the NHS Litigation Authority. Does that mean it uses mediation? To a small extent yes, but in general it is about reducing costs of litigation rather than reaching agreements. It is often accused of being adversarial and purposefully delaying cases to get beyond the three-year civil liability threshold. It is even known for threatening traumatised families with high court costs if they challenge the NHS.

In 2017–2018, the NHS was faced with claims of £2.1 billion on cases of maternity-related clinical negligence. Compare that to the £1.9 billion per year that is spent on birth care.'[6]

Mediation would be a great way forward in saving NHS funds but, more importantly, in restoring the balance of power, with consumers being listened to and lessons being learned by the NHS. There are plans to adopt the rapid resolutions model from Sweden. That would give more rapid closure and learning for families and staff.

Midwifery resolution in New Zealand Aotearoa as a model to adopt

In New Zealand, birthing and pregnant women and their families can make a low-level complaint to the New Zealand College of Midwives (NZCOM) Resolutions Committee.[7] This was started by midwives and local consumer representatives to make an easier process for resolving concerns. This is achieved with third-party clarification by the midwife as mediator. They can make professional recommendations only as they do not have any disciplinary powers. It is the process of actively listening and following up with feedback to both parties by the mediator which facilitates resolution. (If it were simply listening without action, it would be counselling.) This form of resolution is an example of humanistic shuttle mediation where the midwife as mediator sees both parties separately and is focused on active listening. The mediation is non-directive and dialogue-driven. I have proposed this to the UK's Royal College of Midwives without success so far. So, for now, it is down to us to mediate ourselves, finding others to mediate when possible.

Article contd.

Conclusion

Women do have choices and rights in childbirth. They can sometimes go to another provider. They can birth out of hospital at home, and many women can birth in a midwifery unit or birth centre. Getting the best from our carers *can sometimes* depend upon how we discuss what we would like. All women should be treated with respect and dignity no matter how they approach their care. In general, the law assumes and provides for parental responsibility and mental capacity. When we all stand up for our human rights and help others by shining a light when there are challenges, we create the change we wish to see. Let us create opportunities to transform fear into the courage to love through mediating peacemaking with **compassionate communication**.

Paul Golden is a global midwife lecturer and professional mediator. He offers birth mediation courses for healthcare providers, midwives, doctors, doulas and families (online and in person). He is an expert witness report writer globally attending court and regulatory proceedings.
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Further reading:

The Dynamics of Conflict Resolution: A Practitioner's Guide by Bernard S. Mayer 2012 Pub. Jossey-Bass

EVENT:

London Maternity & Midwifery Festival 2020

When: 21st January 2020
Venue: ILEC Conference Centre, Earls Court, London SW6 1UD

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Article

Embracing the female Body: What can we learn from history?

By Gemma McKenzie

In 1892 Charlotte Perkins Gilman published a short semi-autobiographical story entitled 'The Yellow Wall-Paper.'[1] It is a fictionalised account of her own experiences with what we may now describe as post-natal depression. In it the unnamed protagonist is confined to bed where she becomes obsessed with the intricate design of her hideous yellow wallpaper. As the story develops, her mind deteriorates to the point of madness, and she begins to hallucinate a woman struggling to escape the patterns on her wall. Her husband and brother are eminent physicians, and they are convinced that her illness is nothing more than 'a slight hysterical tendency.'

Gilman based the story on the treatment she was prescribed by a famous neurologist of the time named Dr. S. Weir Mitchell. Known for the creation of the 'rest cure,' he advocated that patients with hysteria – who were almost always women – should be confined to the home, live as domestic a life as possible and in Gilman's case, 'never touch pen, brush or pencil again.' Imbued with sexist overtones, Mitchell's ideas were based on the belief that women were mentally weaker than men and could therefore not handle too much 'brain work.' As he described in his 1871 book 'Wear and Tear,' regarding 'the physical future of women they would do far better if the brain were very lightly tasked.'[2]

Being considered mentally and emotionally weaker than men was the starting point for many 'treatments' inflicted on women during the nineteenth century. Elaine Showalter describes how some doctors would prescribe bizarre – and in many cases – inhumane 'treatments' to women and girls so as to control natural physiological processes and urges. She provides the example of a Dr. Edward Tilt who believed that 'menstruation was so disruptive to the female brain … that it should be retarded as long as possible…'[3] According to Tilt, the way to do this was for mothers to ensure that their daughters 'remained in the nursery, took cold shower baths, avoided feather beds and novels, eliminated meat from their diets, and wore drawers.'[4] The natural onset of the menstrual cycle was therefore something to be avoided and controlled, and menstruation itself was pathologised and considered harmful and disease-like.

More disturbingly, menopausal women who expressed sexual desire were recommended by the obstetrician W. Tyler Smith to undergo 'a course of injections of ice water in the rectum, introduction of ice into the vagina, and leeching of the labia and the cervix.'[5] Similarly, Dr. Isaac Baker Brown carried out clitoridectomies (surgical removal of the clitoris) on women he believed to have gone mad due to masturbation. From Showalter's account however, it appears that this type of surgery was most frequently carried out on women whose 'madness' was demonstrated by their refusal to conform to society's expectations. She gives the examples of women who were operated on who had attempted to divorce their husbands, one who spent 'much time in serious reading,' and another who enjoyed 'long solitary walks.'[6] Perhaps unsurprisingly, these doctors were convinced of the success of their therapies; it seemed to escape them that

their patients' new-found docility could be based on shock, trauma and horror. What these examples demonstrate is that during the nineteenth century, women's natural physiological processes and urges were considered at best bizarre, and at worst as things that require immediate surgical intervention.

In 1990, the anthropologist Robbie Davis-Floyd wrote a seminal article on the technological nature of birth in the USA.[7] She argued that medicine treats the body as a machine, and that the male body is treated as the prototype. As medicine developed, the female body was regarded as 'abnormal, inherently defective, and dangerously under the influence of nature.'[8] What this results in is the belief that the female body is the defective version of the male. The question I therefore want to pose, is whether any elements of this belief linger in the twenty-first century maternity system?

With the exception of puberty and age, the male body remains largely static. The female body, however, is cyclical. Girls become women. We experience monthly ovulation and menstruation, and these cycles can last thirty years or more. Most of us experience pregnancy, birth and lactation, and some more than once. We then go through the menopause, and perhaps only then are our bodies as 'static' as our male peers. But how does the maternity system embrace our unique 'femaleness'?

During pregnancy and birth are bodies change dramatically and this is arguably when we are most obviously physically different from our male counterparts. During this time, our bodies are highly regulated, viewed as machine-like and constantly compared to a standard of normality. Many labouring women are confined to beds, their natural urges to move, to change position, to stand or to kneel prohibited. Our bumps are measured, our contractions timed, our cervixes checked for dilation. In a third of pregnancies, labour is started for us via chemicals or cervical balloons, and a similar number of pregnancies end in surgery or instrumental delivery. Things are done to us, and sometimes without our informed consent. The system expects us to behave, to conform and to submit. Birth is not always a celebration of women's uniqueness and reproductive power but can often feel like something to be endured on a conveyor belt in a manufacturing plant.

We can look back on the nineteenth century and its medical management of women's bodies and shudder. Clitoridectomies, leeching the cervix and taking cold showers to us appear stupid and cruel. Yet these were recommended by educated doctors based on their perceptions of medicine and science, and their understanding of women's bodies. We now know their understanding was primitive and imbued with the sexist and misogynistic culture of the day. But what will the people of the twenty-second century make of the maternity system's treatment of us? Is our system without sexism and misogyny? Could some of the 'treatments' doled out to us also be considered stupid and cruel? Is there still a lingering belief that our bodies are defective, and the medical management of our natural physiological processes is the most appropriate way of supporting us to safely give birth?

What we can definitely say is that the maternity system has improved since the nineteenth century. Health care providers know far more about the human body, and have more techniques, skills and technology at their disposal. Yet the system is far from perfect, and it has not yet escaped its sexist shackles. We can only hope that the maternity system continues to evolve in a way that precludes the types of criticism we level at our predecessors, and instead develops safer and more holistic ways of embracing our pregnant and birthing bodies.

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Interview with Kemi Johnson

By Rachel Baldero

When did you get involved in birth issues, and why?

When I was fifteen years old, I wanted to become a midwife and actually had an argument with my dad because he wanted me to become an obstetrician as I had good grades. To keep the peace, I chose instead to have a career in accountancy. It was going pretty well and I became self-employed, which enabled me a little more time, and I used this to become a doula. This of course was all unofficial and unpaid and I became inspired by a person's ability to give birth.

In my late thirties, I actually started my training to become a midwife. The births of my own two children were negative. I had a healthy pregnancy but was induced with my first child as my blood pressure was a little above what it had been previously. At the time I didn't ask any questions; I was 24 years old, excited to meet my baby and had blind trust in the professionals around me. If I knew what I know now, I would have been asking lots of questions about the recommendation to induce my labour! After my birth experiences, it became a very strong instinct in me that I absolutely needed to become a midwife. It took another decade for me to have the courage to go for it – I took the role too seriously to go for it before I knew I was truly ready to give my all; to be of substantial benefit to parents and their children.

How did you become aware of AIMS?

I'm a huge admirer of AIMS and at one time Beverley Beech came into my university, and talked with us for an afternoon. This inspired me to find out more about what AIMS did and how important the organisation was. AIMS is extremely passionate and authentic and it's actually part of the KG Hypnobirthing curriculum for parents to read AIMS books and to take a look at the articles available – I loved the recent AIMS induction article that studied the statistics for stillbirth.

AIMS just get it. I love reading research but have no interest in wading into being a research midwife. I love facts and stats, and learning how parents actually feel about their pregnancy, childbirth and infant nurture experiences. I adore learning more about birth physiology and the biomechanics of birth. I am frustrated that there are prominent birth professionals who have little knowledge, or interest in these subjects and it has me despairing for the future of maternity care and humanity. Really. I have no time for or interest in sitting down with academics discussing research and stats while parents are still being coerced onto beds with their legs in the air reducing their pelvic volume and range of movement of their sacrum & coccyx, and while 90% of those giving birth vaginally are suffering wounded perineums, vaginas and vulvas. I have recently seen a picture of an obstetrician assisting a birth using forceps *with the parent in an upright position! Phenomena*l! Now *that's* the type of birth keeper I would gladly have discussions with. It is about our work being of *true* benefit to families. We are seeing research from America, which has a shameful level of maternal deaths for a developed country, being taken seriously around the world comparing doctors' interventions in one week of pregnancy with doctors' interventions in a later week of pregnancy, rather than comparing interventions with no interventions, and then using this frying pan vs fire scenario to inform practice and write protocols. I despair, I really do. No consideration given to how birth actually works and offering an answer to a question that has already been answered multiple times – midwifery led Continuity of Care from a known carer; all of this meddling is illogical. It's just not right. They are playing with the health of all, current and future whole health of families.

Can you tell me about some of your achievements in this space?

I would rather talk about the achievements and capabilities of parents. What is impressing me about families right now, is that despite the press giving wrong information, despite the coercion and fear mongering around spontaneous, physiological birth even by those that ought to know better, families are still able to wade through copious information, believe in themselves, ask questions, evaluate the answers and then wait for spontaneous birth anyway. It makes me emotional that families are still having spectacular births and are producing the strongest next generation that they possibly can. To be a strong, healthy human, brought earth side by the interplay of hormones between parent and child, and the effect on their bodies and birth happening at the optimal time for both, and then able to access gut flora from their parent's vagina and anus, and their last third of blood from their placenta via an intact umbilical cord following birth… well, you cannot give a human a better start than this. This is only because families are striving to achieve this and some of them having to invest thousands of their own money to make this happen, and this is astonishing. That is where my admiration goes and if these families did not exist, I wouldn't know what I know.

What changes have you seen in maternity care – for the better or worse?

The conversation about the microbiome is huge and so important, and is only something I've seen more recently. Toni Harman is a filmmaker and she invested everything she had to create a movement that started with a film called "Microbirth" and now everyone is talking about it! The BBC have produced a documentary about how poorly children are becoming with the misuse/overuse of anti-bacterials and antibiotics. I am so full of joy that this is a conversation now.

I'm also completely obsessed with people starting their lives with all of their blood, not just two thirds of it (as around one third of blood is still in the placenta if the umbilical cord is clamped immediately after birth). Amanda Burleigh managed to change this with the introduction of delayed cord clamping into NICE guidelines and immediately then started her campaign for 'Wait for White'- optimal cord care. This is a huge difference and it will change a generation. At the moment, many clinicians working within our services still don't get that a baby having their full blood compliment at the start of their lives as independent little humans on the planet will be beneficial for their organs, their whole health and their lives.

KG Hypnobirthing being taught to parents and now to midwives and obstetricians is rocking my world and those of the parents who are dealing with their fears, confidently making decisions, knowing their rights and having more comfortable births. Their babies are being more gently born. It's my reason for being and such a wonderful change in maternity care that I am a tiny part of.

Also birth pools. There are now many installed on obstetric units (really hoping they are being used). The evidence on the benefits of water birth is in and it's really good news. If a parent can be kept comfortable with water rather than proceeding to the use of an epidural then that'll be far less instrumental and surgical births, far fewer wounds to the perineum, vagina and vulva, shorter established labours and most importantly satisfied parents of gently born children. Also it would save maternity services a load of cash! Win Win!

What is the biggest challenge for UK birth activists going forward?

I think we are making massive inroads and so the backlash is becoming stronger from proponents of the technocratic birth model. The fact that parents are listening to physiological birth activists, listening to themselves and then making their own choices – and thankfully in the UK it's the pregnant person who is legally in control of what happens to them – means that parents are gradually taking back control of their birthing circumstances. Previously it was easy to steer most parents into whatever suited the hospital – fearful, poorly informed parents and society at large are far more vulnerable and much easier to control. Parents are now gaining knowledge and retaining their power. Those who have previously had all of the power will cling tighter to it now that it is being challenged.

What do you hope for the future of AIMS and UK maternity services?

AIMS work incredibly hard with minimal resources and because of the maternity services we currently have, AIMS's work is especially challenging right now. I would hope that in the future they do not have to work quite as hard because

more of those working with birthing people have a greater knowledge and respect for how childbirth actually works; this will allow AIMS to spend more time producing their own books & articles that will lead to more parents having access to unbiased materials to enable them to make the right choices for them and their children.

Also, it would be beneficial for future holistic health if decent childbirth education started much earlier, when children were at school, rather than when people are already pregnant and more vulnerable to fear and coercion.

Another thing that I think is really important is respect for and protection of the kind of birthkeeper who DOES understand and respect how birth actually works, and is a true advocate for people giving birth and their children. These are the ones getting the most negative attention from those that gain the most from maintaining the idea that ALL birthing people would birth so much better if they all received some kind of medical intervention or assistance. My hope is that before it is too late, society remembers that healthy childbirth existed way before medicine did and can be supported in some wonderful ways other than with instruments and pharmaceuticals. Medicine is excellent at fixing health situations that are broken but really ought to be restricted to that remit. The over and unnecessary use of medical interventions is resulting in high levels of iatrogenic harm much of which is not being acknowledged as there seems to be little interest in long-term outcomes, only short-term gains.

ENCA Meeting May 2019

Debbie and Nadia attended the meeting of ENCA (the European Network of Childbirth Associations, of which AIMS was a founder member) in Zagreb, Croatia.

The first day was a conference on the topic of childbirth education with contributors from around Europe. Talks included the pros and cons of online courses; the growth of "peer-to-peer" education such as Positive Birth Movement groups in Portugal and a similar system established by El Parto es Nuestro (Birth is Ours) in Spain, and the development by Aperio in the Czech Republic of an online tool to help women choose the best hospital for them. This includes input from a questionnaire sent to women who have used the hospital as well as statistics and comments provided by the staff – a good reality check.

A particularly interesting talk came from Liz Kelly, from the Republic of Ireland, on "The potential role of antenatal education in preventing birth trauma." She commented that lack of support and the actions of care providers tend to be cited as the main cause of trauma, rather than the nature of the woman's birth experience. Liz believes that antenatal education could potentially help both in preventing birth trauma and helping to alleviate the effects of a previous traumatic birth experience. To do this it must be independent of the healthcare system, led by properly trained teachers, evidence-based, enjoyable, informative and with an emphasis on building confidence for women and their partners to question and self-advocate.

The ENCA meeting itself was hosted over the next 2 ½ days by the local organisation RODA (Parents in Action). We were very jealous to discover that they have government funding which enables them to pay for a lovely spacious office in the centre of Zagreb and a staff of 6!

This was a great chance to network with colleagues from other European countries and to learn about their achievements and as well as the continuing struggles many of them face. It was a particular pleasure to see Agnes Gereb there, such an inspiring campaigner for women's autonomy in childbirth, and now at last free to travel. *www.aims.org.uk/campaigning/item/agnes-gereb-clemency* .

The meeting also resulted in a relaunch of the ENCA Facebook Group and there are some great posts on there, so do take a look: *www.facebook.com/pg/encaeurope/posts/?ref=page_internal*

Continuity of Carer and Better Births Implementation

By the AIMS Campaign Team

AIMS is highly supportive of Government policy to ensure that women and families receive continuity in the person caring for them in the maternity context. This was a key recommendation of Better Births[1], the National Maternity Review (2016), and is a highly welcome policy commitment – one which builds solidly on the campaigning work carried out by AIMS and other organisations over many years, most recently in the form of our "A midwife for me and my baby" campaign.

What we hear from women is that continuity in the person caring for you improves the quality of maternity care and there is also evidence that it saves babies lives, reduces the risk of premature birth and increases the chances of mothers having a spontaneous vaginal birth[2]. AIMS particularly welcomes the fact that this policy is an important focus in the NHS Long Term Plan (2018)[3], and that its implementation will benefit from extra resources in that context.

AIMS does not underestimate the enormity of this planned transformation, to a maternity service which is solidly rooted in a continuity of carer model of care. We are keen to support the implementation programme in whatever way we can, including through our role on the *Maternity Transformation Programme's Stakeholder Council*. **At the current stage of the implementation programme, three years on from the publication of Better Births, we would draw particular attention to the need to maintain implementation momentum within a clear framework of social justice, to the need for robust quality assurance mechanisms, and to the utmost importance of transparency and accountability as this programme is implemented.**

A: Maintaining Momentum

AIMS recognises that this policy represents a transformational programme of change, one which will take many years to deliver in full. AIMS is pleased to see that a steady pace of transformation is now being encouraged by the adoption of specific interim targets across the country: these targets set a welcome pace, which should ensure that implementation momentum is both encouraged and sustained. To organise the roll-out of this programme, AIMS is pleased to see that stepped targets for midwifery continuity of carer have been set. These targets are for 20% of all women booked onto maternity care to be booked onto a continuity of carer model of care by March 2019; this target rises to 35% by March 2020, and again to the majority of women by 2021 (NHS England, 2018)[4].

- AIMS calls for regular reporting of progress against each of these targets in every area of the country, including at the level of individual Trusts providing maternity care.

In addition, there is a parallel target for continuity models of care to be provided to 75% of BAME women by 2024, with a similar target to be reached in respect of women from deprived groups (NHS 2018)[5]. AIMS is keen to see co-produced local plans in place that provide priority groups of women with continuity of carer as the roll-out progresses. These should be well-considered and in line with the Government's priority targets. Continuity of carer should NOT be offered on an opt-in basis.

- AIMS calls on every LMS to evidence how the local roll-out strategy has been developed with equity in mind, and to analyse and publish data on which groups of women have been moved onto a continuity of carer model of care as the roll-out of this policy proceeds.

B: Quality of implementation

AIMS believes that it is of utmost importance that new configurations of care are implemented sustainably and that robust quality assurance mechanisms are in place.

- AIMS calls for the development of clear national standards for continuity of carer models of care, against which the quality of local implementation can be assessed.

AIMS is keen to see evidence that the models of care that are being developed and delivered offer authentic continuity of carer. In particular:

- AIMS insists on all continuity of carer models of care having, at their core, a clear expectation that a named midwife will deliver all of a woman's midwifery care wherever possible, with occasional support from one colleague or a small team of colleagues as necessary.
- Where women are offered ongoing care from other healthcare professionals as part of the wider maternity care team, AIMS is keen to increasingly see continuity of the person caring for them (eg an obstetrician) becoming part of standard care.

AIMS has exemplified what we understand to be women's expectations of this model of care in the AIMS 'I' statements here (AIMS, 2018).

C: Accountability and Transparency

As with any quality improvement programme, AIMS calls for this programme to be taken forward within a positive culture of transparency and data sharing:

- AIMS calls for published reports on the quantitative progress being made against the annual targets, at the national, regional, LMS and Trust level;
- at the LMS level, in advance of national quality standards being implemented, AIMS calls for six-monthly published reports which descriptively review local implementation progress and offer forward-looking plans, including a clear statement of any additional resources needed;
- AIMS calls for all local implementation reports to be co-produced with local MVPs/ in collaboration with local service-users.

Conclusion

AIMS is certain that the successful implementation of this policy will mark a hugely important step forward. It will improve the ability of the many extremely hard-working and highly valued staff in our maternity services to offer individualised care to each woman and her family, making a real difference to the lives of women and families. AIMS looks forward to a time when we no longer talk much about a continuity of carer model of care, because this will be the standard model of care offered to all women and families. For this to become reality, let us work together now to ensure that this implementation programme is a success!

If you have any comments or suggestions for the AIMS Campaigns team, or want to get involved in our campaigning work, please get in touch with us at campaigns@aims.org.uk.

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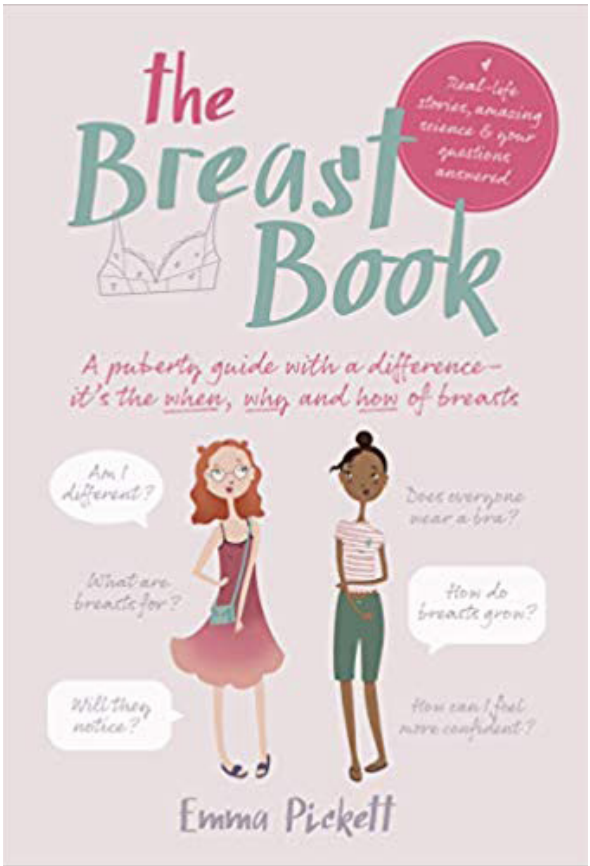
The Breast Book: A puberty guide with a difference – it's the when, why and how of breasts

by Emma Pickett

Pinter and Martin Ltd 2019
ISBN 978-1-78066-475-0
176 pages
Publisher's recommended price: £8.99



The Breast Book is certainly a very interesting book! As it states on the front cover, it is 'a puberty guide with a difference'. Whether you're 10, 15 or 40 years old, this book will be a great and unique read; I guarantee you won't get bored!

Emma Pickett is an amazing and funny author. She has the ability to explain things so that you can understand them but also relate to them. It is almost as if she has designed the book specifically for you, as it is easy to read, and could have you reading it in one whole go!

I think everyone should read The Breast Book, no matter who they are; pretty much all questions are answered in this book. It literally tells you the when, what, why, where and who of breasts! The parts I most enjoyed in The Breast Book are the real-life stories about other people's experiences. I like finding out about other people, who are actually alive, rather than the science behind things. In my mind, it's important to know what's going on in the world around you, otherwise you're just living in a shell. But all opinions will vary from one person to another a lot! The Breast Book will reassure you about any burning questions that you may have, that you are too embarrassed to talk about. Reading it is almost like you are talking to someone. Some people might feel that they can mention breasts to anyone; however, for slightly shyer people, this book is perfect.

I recommend that everyone reading this review reads The Breast Book. Simple! It would make an ideal present for teens. 😉😊

Reviewed by Clara Hubbard, age 12

Book Review Editor comment:

It's great to hear about this book from Clara, as she is certainly part of Emma Pickett's target audience. I was interested that Clara was not so keen on the 'science': I found those sections of the book amazing and I was very pleased to read them. I have had to attend many conferences and read widely to access that information, and I felt that Emma has done a great job in this book of making the science around birth and breastfeeding wonderfully accessible to young women. It is possible, of course, that more of the science sunk in than Clara appreciates right now.

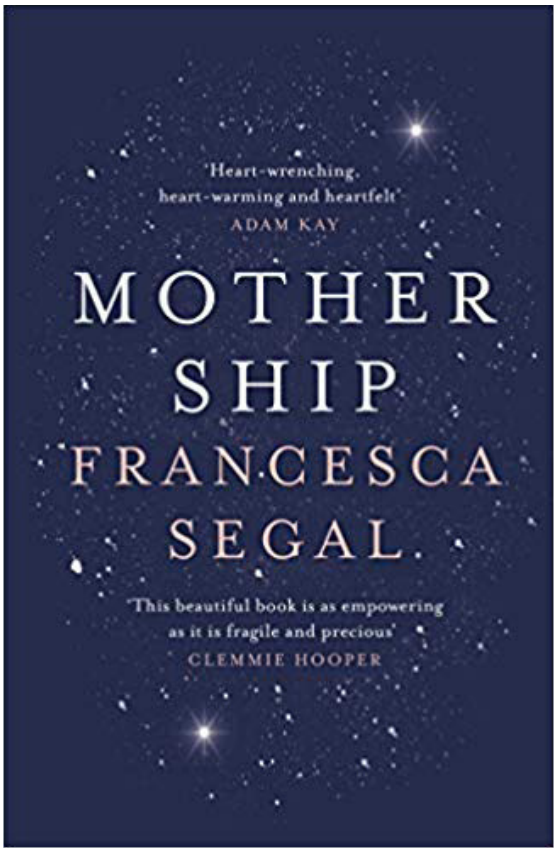
My other reflection on reading the book was to think that young men need to be reading much of this book too – especially the science bit. I'm not aware of other books on the market that meet this need, and so I would dearly love to see Emma adapt the material and produce a companion book aimed at teenage boys.

Mothership

by Francesca Segal

Chatto and Windus, 2019
ISBN 978-1-78474-269-0
286 pages

Publisher's recommended price: £14.99



According to Bliss (a charity supporting parents of babies who are born prematurely or unwell), one in seven of all babies born in the UK spend some time in neonatal care. Whether the stay is short or long, it is an experience that has a lasting impact on every family involved, and it is good to see a new book on the market that allows outsiders a glimpse into this rather hidden but hugely valued part of the NHS.

As an established novelist, Francesca Segal is clearly at an advantage in writing about her time as a new mother whose twins are being cared for in a neonatal intensive care unit (NICU). In this memoir, Francesca describes the first 56 days of her daughters' lives, until they are ready to go home together as a family.

For readers (like me) who have not encountered life as a NICU mother, Francesca's account offers a compelling insight into the experience. It shares some of the unspoken rules of this unique space and invites us to consider the value of spontaneous peer support, as complementary to the professional support offered. Against the backdrop of a hugely impressive service offer, it allows the reader the opportunity to consider some key areas for service improvement. And, whilst Francesca's account is firmly centred on her experience as a milk-producing NICU mother, the memoir also includes some thought-provoking observations about the role of fathers, too.

The memoir doesn't attempt to tell you 'everything you need to know about NICU'. It is a story of one woman's experience: just one of many diverse experiences. But it is no less important for that: this memoir provides a key introduction to many aspects of the parental and baby NICU experience from a parent's perspective.

This book would make an excellent read for anyone planning to work with families accessing neonatal care. I'd also recommend it to anyone involved in maternity/neonatal-service improvement, including Maternity Voices Partnership members, both with and without personal experience of having a baby in NICU.

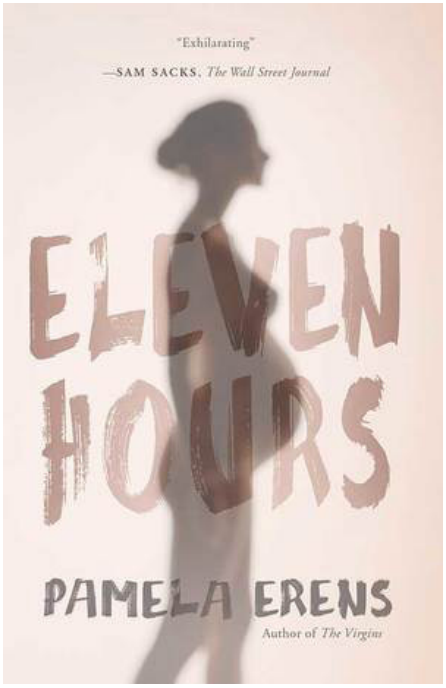
Reviewed for AIMS by Jo Dagustun

Eleven Hours

by Pamela Evans

Tin House Books, 2016
ISBN 978-1941040294
176 pages

Publisher's recommended price: £12.99



This short fiction novel follows two main female characters, Lore and Franckline, through eleven hours of their lives, as Lore labours in hospital and Franckline supports her. I thoroughly enjoyed reading Eleven Hours and almost instantly connected with Lore and Franckline, wondering how their individual stories would develop.

Lore is in labour and has made her way to the hospital alone. At the hospital, she is attended by midwife Franckline. The story is set in New York in 2004, so about 15 years ago. Throughout the novel, however, readers are sent back further in time, following snippets of memories from each character and learning a little more about them and how they came to be in their current situations. As the labour progresses (or doesn't, at times!), Erens explores the effect of different elements of the hospital environment on the birthing process, telling this both from the point of view of the patient and the caregiver.

I found the balance between accurate medical description and captivating storytelling absolutely perfect. I find it essential for any book, fiction or non-fiction, to be accurate in its portrayal of childbirth and this can certainly be said of Eleven Hours. At the same time, when we are looking into the memories of Lore and Franckline, there is a beautiful, easy descriptive style that draws you into the storyline and ignites empathy for both characters. Some readers may find it difficult to follow the sudden jumps between characters and memories, however I personally didn't find this a problem. On the rare occasion that I hadn't noticed a switch in time period, it very quickly became obvious where and when the story had leapt to.

I found it particularly interesting, and appropriate, that this book has no chapters. It is one long story from start to finish, which I think is an excellent reflection of labour and birth, where one phase simply flows into the next with no defined stopping point. It also makes for a fantastic page turner, as there's never a good place to put it down!

A main theme of the novel is the medicalisation of birth and the failure to respect, or even enquire about, the wishes of the woman giving birth. Initially I assumed, wrongly, that the midwife, Franckline, would be the stereotypical unsympathetic midwife, largely ignoring the detailed birth plan that Lore has written. But this obvious narrative was not drawn on at all and the author uses minor characters throughout to illustrate how care during labour can be seen and felt in a positive or negative way. Franckline is, in fact, a beautiful example of how the correct sympathetic care can have measurable effects on a woman's labour progression. Lore's character is hugely complicated. Although she has carried out a huge amount of research and gained valuable knowledge, she is finding that this hasn't replaced true and continuous support from a birthing partner in the way she had hoped. The book also celebrates how modern medicine saves lives of both babies and mothers, offering something of a juxtaposition against the general subtext of a hands off birthing approach.

I would absolutely recommend this book, although would advise caution to anyone reading it while pregnant, as certain elements may feel worrying to someone approaching the time of their own labour. The descriptive elements are wonderfully absorbing and the characters believable, and likeable in their own ways. The ending is brilliantly indefinite, which for a moment I found frustrating before realising that any other finish would have been clichéd in one way or another, going against the carefully considered realism of the rest of the story.

A short and easy, but involving and thought provoking, read.

Reviewed for AIMS by Emma Mason

EVENTS

London Maternity & Midwifery Festival 2020

When: 21st January 2020
The London Maternity & Midwifery Festival will be returning to the ILEC Conference Centre in Earls Court on Tuesday 21st January 2020. For more information, *www.aims.org.uk/events/item/london-mmf-2020*

The Baby Lifeline National Maternity Safety Conference

When: 22nd January 2020
8am - 6pm on 22 January 2020 #MatSafety2020 The conference includes presentations and panel discussions. For more information, *www.aims.org.uk/events/item/baby-lifeline-safety-conf*

Future Midwife Celebration Event

When: 12th February 2020
12:30 – 14:30 on Wednesday, 12 February 2020 This is an NMC event to celebrate the launch of their new future midwife standards. To register, *www.aims.org.uk/events/item/future-midwife-celebration-event*

AIMS Volunteers Meeting

When: 22nd February 2020
Details TBC

Perinatal Mental Health Maternity Study Day 2020

When: 5th March 2020
8.30am - 5pm Study day, including networking breaks and lunch, with sessions on the following topics: Bipolar support in pregnancy and planning. For more information, *www.aims.org.uk/events/item/perinatal-mental-health-maternity-study-day-2020*

Midlands Maternity & Midwifery Festival 2020

When: 23rd April 2020
The festival runs from 8am to 5pm on 23rd April 2020 and includes expert speakers, an exhibition, seminars and an awards ceremony. For more information, *www.aims.org.uk/events/item/midlands-mmf-2020*

Northern Maternity & Midwifery Festival 2020

When: 9th July 2020
The Northern Maternity & Midwifery Festival will be returning on Thursday 9th July 2020. There is a call for papers and award nominations ... For more information, *www.aims.org.uk/events/item/northern-m-and-m-fest-2020*