AIMS For a better birth...

Reflections on current trends in maternity care: a stream of consciousness

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Editor: Joy Horner first trained as a midwife in 1988 and practised for 18 months before deciding that subjecting all first-time mothers to episiotomies and using syntocinon infusions on everyone in labour, and calling it active management of labour, was not what she wanted to do. She thought she was a bad midwife, so she returned to being a registered nurse and didn't go back to midwifery again until 2002 after she had completed a diploma in antenatal education with the National Childbirth Trust. She left the midwifery register in March 2021 due to a multitude of factors; being an independent midwife meant she could no longer attend births because of the lack of intrapartum indemnity insurance, and as she was getting older she no longer wished to be subject to the punitive behaviour of the NMC (The Nursing and Midwifery Council) and increasing restrictions on her practice. When asked to write about induction of labour she realised she had a lot to say on the subject from a less mainstream perspective.



By Joy Horner

In my years as a midwife I learned a lot from families I served, especially the families whose choices were outside of guidelines. They showed me what it means to have faith in women and birthing people's abilities. As an independent midwife my education in normal birth, human rights and autonomy skyrocketed. I saw things that doctors said shouldn't happen, couldn't happen, and yet they did happen; things that you don't find in textbooks or from randomised control trials, because birth works best when it is unobserved and undisturbed. I became less hands-on as my clients often declined blood tests, or vaginal examinations; they did not want electronic fetal heart monitoring or for their baby's cord to be

cut soon after birth, and they often did not want any talking during their labour. Intuition plays a big part and I embraced spiritual and shamanic dimensions of this sacred rite of passage.

As a recently retired midwife I am used to looking at research-based evidence, but my training in 1988 was definitely more practical. Active management of labour for all clients, and performing an episiotomy on every first-time mother, was considered good practice; now research shows it causes more harm than good. Science didn't know everything then, and it doesn't know everything now. With medical management on the increase, we shouldn't close our minds to the possibility of something we are doing now being proven harmful in the future – or that important factors that have not been studied or that we do not yet understand will come to light and radically change the way we care for people in labour. For example, when I started training I never imagined there would ever be a thing called epigenetics let alone mapping the human genome.[1] These things were a mystery then.

I have respect for our NHS, our doctors, our midwives, our surgeons, anaesthetists, and those who provide science-informed care when we really need it. As a born sceptic, I never take things at face value, and I have to understand exactly why I'm being asked to offer a procedure or treatment. My grandmother used to say, "Believe nothing of what you hear and only half of what you see", but nevertheless, growing up with the stories of my own and my siblings' births in the 1960s has left me with an innate belief in birth. None of us was born in hospital, including a sibling who weighed in at 11½lbs born at 44 weeks of pregnancy, at home, to my 5□3□ pre-diabetic mother. In the 1960s the *art* of midwifery was more widely trusted and respected.

When the Peel report in 1970[2] encouraged all women and pregnant people to give birth in hospital, we started to forget that we can give birth without hospitals and doctors. Hospital became seen as a place of safety where experts could save all women and all babies. As we know, the move to institutionalised birth has not made birth safer across the board, and now we are seeing more cases of iatrogenic harm[3] and more women and birthing people who describe their experience as traumatic. As midwives and birth keepers, we need to maintain the balance between the art and science of midwifery – and to acknowledge the mysteries that remain.

In 2015 I did a year-long shamanic womancraft training with Jane Hardwicke Collings. It helped me see the interconnectedness of our lives, within the wider context of the seasons, moon phases, our family lineage and childhood experiences. It helped me connect with my own spirituality and to see even more of the spiritual side of pregnancy, birth and becoming a parent.

I am currently training with Matthew Appleton in the field of integrative baby therapy,[4] the roots of which are pre and perinatal psychology. Integrative baby therapy acknowledges that babies are conscious beings in the womb and throughout birth, and have experiences that they remember and tell us about even in the preverbal stage. We also look at how birth can affect babies and how trauma can be carried from generation to generation.

I read a book by Mark Wolynn called, 'It didn't start with you: how inherited family trauma shapes who we are and how to end the cycle',[5] which describes how prolonged stress in a parent can affect

epigenetic changes in their offspring demonstrable for at least three generations. I consider it essential that anyone supporting families expecting a baby talks with them about ways to manage their stress levels and where they can get help.

Being a born sceptic has given me a very inquiring mind eager to find out the wider truth. I also inherited my father's sense of justice and equality for all. I have been a defender of human rights for as long as I can remember; as a midwife, the rights of a person in front of me have always been paramount. However, from personal and professional experience, I understand the unpredictable nature of birth and the benefits of medical intervention when needed. Women and birthing people also have a right to understand this and to know when they might welcome medical support. So when the theme of induction comes up, I discuss the medical recommendations, the NICE guidelines, and any information on which clients can balance their decisions. When my clients decline the offer of induction they do so from a point of being extremely well informed; they have considered all the options, looked at all the risks and benefits, and made the decision that they feel is right for their baby. No-one in my care has ever made a decision that is neglectful of their baby's well-being. As a midwife and now birth keeper, it is my duty to support their decisions no matter what my personal beliefs may be.

It is not easy supporting clients who choose not to follow guidelines and policies; it takes courage. I have supported many 'high-risk' births at home including VBAC[6] clients with breech-presenting babies. Sometimes these families have rewarding empowering experiences that prove the doctors wrong, but occasionally a baby has died. In these tragic circumstances we truly learn the nature of spirituality as we call out to everything that is holy to help us understand. Of course, in many of these cases the outcome would not have been better in a hospital situation.

Asked why I think the induction rate is increasing, I say it's not just because of NICE guidelines or because of rising insurance premiums; it is to do with economics, our social and our cultural expectations around birth, and our belief in the paternalistic and technocratic maternity system. We live in a culture where nobody likes to wait and where we have been brought up to rely on 'experts' to know what is best for us; in doing so we have lost touch with a more instinctive way of being. When I was born in the 1960s my parents had to trust that they were just carrying one baby, that the baby would be healthy, and that labour would start when the baby was ready to be born. They knew that most labours went well, and most babies were born healthy. Neonatal mortality has improved since the 1960s,[7] but at what cost? The number of inductions needed to save one baby is in the hundreds,[8] and those treated unnecessarily may be left with physical or mental birth trauma. However, for the family of that one baby, all that matters is that their baby arrives safely.

We no longer have such large families so there is a lot of expectation that children will survive childbirth and infancy. In my grandmother's day people had larger families and although it was hard it was widely accepted that some babies would die during pregnancy, birth and childhood. Because we invest so much in our children we ask the help of the experts, hoping to improve their chances of health and survival. Yet scientists, researchers, doctors and midwives may also not know how best to achieve this. The industrial revolution and the advent of the NHS made way for a growing reliance on the skills of 'professionals' and

on state-provided services. Over time this resulted in a loss of individual skill and autonomy, and a loss of trust in our own instinctive decision-making ability. Of course, when the NHS first started, the belief was that it would provide free care for everyone – but with medical advances and the increasing cost of equipment and drugs, it has been a victim of its own success. Hospitals are millions of pounds in debt and have to look to save money wherever they can. This includes cutting down on staff and other resources, which ironically compromises safety and contributes to far more costly litigation claims.[9] With fewer staff to provide continuity of care we have to rely on technology for the information that we used to be able to get from spending time with families, taking good histories, forging trusting relationships, and good palpation and auscultation skills.[10] It can sometimes be easier to look after someone who has an epidural and may even be asleep, than the woman or person giving birth in the next room without analgesia who may need a hand to hold, and soothing words after each contraction. Furthermore, staffing levels are easier to manage when we can control and predict the flow of people onto the labour ward. This can be achieved by saying that *all* women with a particular due date will give birth by that date plus a given number of days – either spontaneously or by induction.

We can inform clients of the chances of an undesired outcome according to research, but that research has not included the unique individual before us. So when counselling families about induction I give accurate information so they can make informed decisions, but also explain the uncertainty involved. We look at the multifactorial reasons why pregnancies can last beyond 42 or even 43 weeks. A personal or family history of longer pregnancies and being older might increase the chances of having a baby that is post-term. We also have open and honest discussions about why babies die. As an independent midwife, any baby death leads to an investigation and when this has happened with me I have been cleared of any wrongdoing; yet each time I support one of these families I search my soul for what I could have done differently. I became a trustee of a baby-loss charity 10 years ago and I learned that quite often no reason is found, even after a post-mortem. Science knows a lot but not everything. Not all babies will survive pregnancy or birth yet this is not discussed with parents. We may fear undermining parents' confidence in medics, but I have learned that if I admit to not having all the answers (which none of us does), my clients feel more empowered to trust their intuition. It seems that honesty about the limitations of science allows people to reclaim their ability to tune in to what they truly need in their pregnancy and birth time.

We know that labour is initiated by the baby when the pregnant person is ready to give birth and that occasionally there are physical and emotional reasons why the onset of labour is delayed. Physically, the baby may not be in an optimal position – if the baby has not engaged or is in a deflexed position that could prevent labour starting. Emotional reasons may include fear of giving birth, fear of becoming a parent, fear of having a child of a particular sex, or fear because one is not in a safe place or with safe people. If we treat the baby as a conscious and emotional being, we can entertain the thought that the baby has some agency over entering the world and might be reluctant to do so.

I have cared for people whose babies have been stillborn who have told me retrospectively that they had a sense that their baby would not survive birth. It seems as if the extended pregnancy did not cause the baby's demise but may have prolonged his or her life in the womb. I have been told by people after a birth

that they have a strong sense that not going into labour or not giving birth vaginally, though disappointing at the time, somehow protected them from a birth complication that might have happened otherwise. Women talk about these things but they remain a mystery to science.

Why would clients choose not to be induced? The choice might be because of: cultural reasons; deep fear of hospital or intervention as a result of previous trauma; belief in birth and nature, and faith that their baby will be born healthy without intervention; the knowledge that intervention is not benign; and religious or spiritual beliefs that take into account the fact that some babies die even with the best care, and that whatever happens is divine or cosmic will.

With regard to intergenerational trauma,[11] I have helped clients make their own connections between what happened in their labour and birth and something that happened in their childhood or to one of their ancestors. A few clients have felt that a postpartum haemorrhage, or unplanned emergency caesarean, enabled their body to be rid of something that they no longer needed in a shamanic or spiritual way. For example, a client who had a difficult relationship with a relative was able to ponder what may have been healed in experiencing a birth that was far from the one she had planned. Previous abuse can make clients unwilling to give birth in a way that involves interventions and invasive procedures, and they can sometimes claim back their power by birthing unassisted with the minimum of medical care. If they were to follow the recommendations to be induced, previous trauma could resurface. In fact, feeling out of control, being in powerless positions, being told to lie down, to be quiet or do as they're told, or invasive procedures such as vaginal examinations can result in a person's first experience of trauma; trauma that is then handed down through the family.

Our ancestors paid attention to other factors that could affect the onset of labour. We know, for example, that the moon affects the tides and women's menstrual and reproductive cycles,[12] and some women decline induction in favour of these natural cycles.

However, many women and pregnant people decline induction because they are very well read, have looked at all the pros and cons, have considered how the current research applies to them in this pregnancy and are making well-informed decisions about what is right for them and their baby.

Regardless of the reasons, anxiety at the end of pregnancy in itself can delay the start of labour. Adrenaline decreases the production of oxytocin. Instead of threatening, coercing and frightening people whose pregnancies continue past 40 weeks, we should help them to rest and relax and increase oxytocin levels. Oxytocin receptors in the uterus increase over time[13] [14] and labour will always start given time.

In conclusion, it is the right of every pregnant woman or person to accept or decline any treatment even if it's thought to be to the detriment of her baby. The NMC clearly states that our duty is to support the choice of the person in front of us. Our clients do not have to give us a reason that they are declining treatment but spending time with them may help us understand their choices. In this way we can increase the likelihood of any birth, induced or spontaneous, being a positive and happy experience.[15]

I want to end with a wonderful quote by Ani Di Franco in Ina May Gaskin's book 'Birth Matters: a midwife's manifesta'. Di Franco describes how, after a long and difficult labour at home, she felt the exaltation of having given birth to her first baby:

> What if the medical establishment that purports to be saving women from the specter of pain and danger is instead ejecting them from the seat of their power? … I have many friends now who have given birth, most of them in hospitals with a myriad of interventions, and a truly shocking number of them by caesarean section. Young, healthy, and strong women. It confuses me that I, an educated, privileged woman in twenty-first century America, am surrounded by women who think they need saving and, because they are denied the opportunity to know otherwise, may believe it forevermore. They look at me with wide eyes and say, "I couldn't have done what you did," and my heart breaks as I think quietly, "yes you could have! In fact, I bet you could have done better!" How could all these otherwise empowered young women go so unquestioningly into the role of damsel in distress when it comes time to have their children? How are they convinced that they "couldn't do it"?

Author Bio: Joy Horner practised as a midwife for 21 years, 16 of which were as an independent midwife, before changing to her current job of birth keeper, or doula.

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[1] Editor's note: Epigenetics is the study of how behaviour and environment can cause changes that affect the way genes work. One group of scientists concluded their study (*The EPIIC hypothesis: Intrapartum effects on the neonatal epigenome and consequent health outcomes*) by saying:
A fundamental tenet of clinical practice is to "do no harm". The EPIIC [Epigenetic Impact of Childbirth] group hypothesizes the routine application of interventions during a healthy childbirth event can alter physiological epigenetic remodeling, with the potential for negative health effects. This suggests that physiological labor and birth is finely tuned to generate optimal epigenetic effects for later wellbeing. It is paramount to the wellbeing and protection of mothers and babies to adequately explore this area of research.
(www.ncbi.nlm.nih.gov/pmc/articles/PMC3612361)

[2] Ministry of Health (1970) Domiciliary Midwifery and Maternity Bed Needs: the Report of the Standing Maternity and Midwifery Advisory Committee (Sub-committee Chairman J. Peel), HMSO, London - https://archive.org/stream/op1269001-1001/op1269001-1001_djvu.txt

[3] Editor's note: Iatrogenic harm is harm caused by medical care or treatment. This study addresses iatrogenic harm in maternity care:

Liese KL, Davis-Floyd R, Stewart K, Cheyney M (2021) Obstetric iatrogenesis in the United States: the spectrum of unintentional harm, disrespect, violence, and abuse. Anthropology & Medicine. 28(2):188-204. doi: 10.1080/13648470.2021.1938510. Epub 2021 Jul 1. PMID: 34196238.

[4] Appleton M (2020) Transitions to Wholeness: Integrating Prenatal, Transpersonal and Somatic

Psychology. Independently published.
[5] Wolynn, M (2017). *It didn't start with you: how inherited family trauma shapes who we are and how to end the cycle*. New York: Penguin Books.
[6] Editor's note: A VBAC client is a person having a vaginal birth after a previous caesarean.
[7] Editor's note: Statistician Marjorie Tew established that the decline in perinatal mortality during the post-war decades was largely due to improved diet and living conditions: https://academic.oup.com/fampra/article/16/3/321/485609
[8] Middleton P, Shepherd E, Crowther CA (2018). Induction of labour for improving birth outcomes for women at or beyond term. Cochrane Database Syst Rev. 5(5):CD004945. doi: 10.1002/14651858.CD004945.pub4. Update in: Cochrane Database Syst Rev. 2020 Jul 15;7:CD004945. PMID: 29741208; PMCID: PMC6494436. https://pubmed.ncbi.nlm.nih.gov/29741208
[9] Lintern S (2021). Revealed: Unsafe maternity care has cost the NHS £8.2bn in 15 years. The Independent. www.independent.co.uk/news/health/maternity-negligence-compensation-nhs-safety-b1902095.html
[10] Editor's note: Palpation (in this context) is when someone examines the pregnant belly and the baby within by using their hands. Auscultation (in this context) is when the unborn baby's heart rate is listened to through the pregnant person's abdominal wall.
[11] Editor's reading suggestion: Hendrix CL, Dilks DD, McKenna BG, Dunlop AL, Corwin EJ, Brennan PA (2021). Maternal childhood adversity associates with frontoamygdala connectivity in neonates. Biological Psychiatry: Cognitive Neuroscience and Neuroimaging,4 6(4):470-478. doi: 10.1016/j.bpsc.2020.11.003. Epub 2020 Nov 21.
[12] Kelleher, S (2021). Moon cycles exert an influence on menstruation and sleep patterns, www.aaas.org/news/moon-cycles-exert-influence-menstruation-and-sleep-patterns
[13] Prevost M, Zelkowitz P, Tulandi T, Hayton B, Feeley N, Carter CS, Joseph L, Pournajafi-Nazarloo H, Yong PE, Abenhaim H, Gold I (2014). Oxytocin in pregnancy and the postpartum: relations to labor and its management. Frontiers in Public Health, 2, DOI 10.3389/fpubh.2014.00001, www.frontiersin.org/articles/10.3389/fpubh.2014.00001/full
[14] Buckley S (2011). Undisturbed birth. AIMS Journal, 23(4), www.aims.org.uk/journal/item/undisturbed-birth
[15] Editor's note: For more information about making consensual decisions about pregnancy and birth read: AIMS, 'Making decisions about your care', www.aims.org.uk/information/item/making-decisions, and Birthrights, 'Consent: the key facts', www.birthrights.org.uk/factsheets/consenting-to-treatment