# AIMS JOURNAL

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ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

## Are you asking?
## considering consent

What does consent actually mean?

Who makes decisions about care?

Report of the Human Rights Conference in the Hague

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Elizabeth meeting her baby for the first time.

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## AIMS Members Yahoo Group

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

# Consent - a commonly understood concept?

*Debbie Chippington Derrick* explores the professional and legal position on consent

Consent is a commonly understood concept, the Oxford English dictionary defines consent as 'permission for something to happen or agreement to do something' and defines informed consent as 'permission granted in full knowledge of the possible consequences, typically that which is given by a patient to a doctor for treatment with knowledge of the possible risks and benefits.' AIMS feels that this should be a very simple concept to implement, but it is clear from the women who contact AIMS that most maternity care falls very short of this mark.

Hearing, as we do at AIMS on a regular basis, about women being led to believe that they have no choice about what is done to them during the birth of their baby we were interested in what various institutions have to say about consent and how the autonomy that this simple concept should ensure seems to be lost in the provision of maternity care.

The Department of Health

The Department of Health (DH) has a reference guide to consent for examination or treatment,[1] the first edition was published in 2001 and the current, second edition was published in 2009. This document states that since 2001 the DH has required NHS Trusts to adopt a model consent policy, model forms and information leaflets with the aim of ensuring that good practice in seeking consent was put in place throughout the NHS. The DH makes the following statement on needing a consent policy:

*'We are aware of the importance to Trusts of having up to date guidance available to them to ensure they continue to have in place effective and legal consent processes. This is especially so at a time when the Care Quality Commission is developing its regulatory framework (and associated guidance) and that there is a continuing need for Trusts to meet the risk management standards required by the NHS Litigation Authority.'*

This suggests that the guidance is more about making sure that institutions are covered on a legal basis than about the quality of the care of patients. The fact that the DH document on consent is 52 pages in length makes it clear that they do not consider it to be a simple issue.

The document states that:

*'For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question (this will be the patient or someone with parental responsibility for a patient under the age of 18, someone authorised to do so under a Lasting Power of Attorney (LPA) or someone who has the authority to make treatment decisions as a court appointed deputy).'*

It also states that:

*'Acquiescence where the person does not know what the intervention entails is not "consent".'*

And goes on to consider issues such as:

- *Is the consent given voluntarily?*
- *Has the person received sufficient information?*
- *Duration of consent*
- *Withdrawal of consent*
- *When consent is refused*

In the case of consent being refused it says:

*'If an adult with capacity makes a voluntary and appropriately informed decision to refuse treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983 (see chapter 5). This is the case even where this may result in the death of the person (and/or the death of an unborn child, whatever the stage of the pregnancy).'*

## none of this should be controversial or difficult to understand

It seems that none of this should be controversial or difficult to understand, the guidance statements are quite clear, everyone has a right to full information about the risks and benefits of any examination or treatment and they are free to decline, even if the professional would advise against it.

### AIMS Stickers - Where will you put yours?

This issue includes a sheet of AIMS stickers for you to use to promote AIMS. We hope that you will use them to raise the profile of AIMS and to help others to find us.

We will be looking for the most imaginative uses of these stickers. Additional sheets can be obtained by emailing publications@aims.org.uk

The NHS

The NHS choices website has a page on consent[2] which addresses consent in a broadly similar way adding that:

*'The principle of consent is an important part of medical ethics and the international human rights law.*

*'Consent is the principle that a person must give their permission before they receive any type of medical treatment.*

*'Consent is required from a patient regardless of the type of treatment being given, from a blood test to an organ donation.*

*'For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.'*

They say *'from a blood test to an organ donation'* however, it is not only invasive procedures that require consent, so is the NHS missing something here and does this give some idea about why there is a failure to obtain consent that covers all aspects of care?

## A principle of consent is that it is given voluntarily

The NHS Litigation Authority's Risk Management Standards 2012-13[3] is very clear about what consent means, they state:

*'A principle of consent is that it is given voluntarily and that sufficient information has been imparted to allow the consent to be valid. It is a legal and ethical principle that valid consent is obtained for every person.*

*'When deciding on the approach for consent, organisations are reminded of the need not only to consider legal requirements but the standards expected of healthcare professionals by their regulatory bodies. All practical and appropriate steps must be taken to enable a person to make the decision themselves. Information should be communicated in an appropriate way, include the nature and purpose of procedures, and the provision of any other relevant information.*

*'If there is a failure to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may give rise to a valid negligence claim.*

*'Analysis of the NHSLA claims database shows a significant number of claims where consent is an issue. The majority of these are in relation to surgical procedures or treatments. A major factor is the apparent lack of adequate, clear information for patients, due to issues with verbal or written communication, or competence contributing to these failures.'*

*(page 122)*

So, the NHS legal defence teams have a very clear statement on what constitutes consent and the potential pitfalls of not gaining proper and informed consent. To not gain consent and to not ensure it is properly informed is negligence. It is expected by CNST (Clinical Negligence Scheme for Trusts) that NHS Trusts and contracted-in services will comply for the purposes of their clinical negligence insurance.

NICE

NICE, the body responsible for producing guidance on evidence-based practice, does not seem to provide an overview on consent, but it is addressed in various ways within the different guidance covering different issues. For example the pathway for caesarean section[4] says:

*'A pregnant woman is entitled to decline the offer of treatment such as caesarean section, even when the treatment would clearly benefit her or her baby's health. Refusal of treatment needs to be one of the woman's options.*

*'Request consent after providing evidence-based information and in a manner that respects the woman's dignity, privacy, views and culture, while taking into consideration the clinical situation.'*

All is clear and relatively consistent so far, so, what do the professional bodies have to say?

The GMC and the NMC

The regulatory bodies for both doctors and midwives provide significant guidance on consent. Information about consent from the GMC can be found in their document *Consent Guidance: patients and doctors making decisions together*[5] and there is a 64 page document *Guidance for Doctors* which lays out the duties of a doctor registered with the General Medical Council.[6]

There are some excellent points, and obvious points are made clear, for example:

*'You should give information to patients in a balanced way. If you recommend a particular treatment or course of action, you should explain your reasons for doing so. But you must not put pressure on a patient to accept your advice.'*

*(page 13)*

## you must not put pressure on a patient to accept your advice

*'You should do your best to understand the patient's views and preferences about any proposed investigation or treatment, and the adverse outcomes they are most concerned about. You must not make assumptions about a patient's understanding of risk or the importance they attach to different outcomes. You should discuss these issues with your patient.'*

*(page 17)*

*'You must respect a patient's decision to refuse an investigation or treatment, even if you think their decision is wrong or irrational. You should explain your concerns clearly to the patient and outline the possible consequences of their decision. You must not, however, put pressure on a patient to accept your advice.'*

*(page 19)*

*'You must not assume that a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), their beliefs, their apparent inability to communicate, or the fact that they make a decision that you disagree with.'*

*(page 29)*

Information from the NMC about consent[7] states that:

*'Nurses and midwives have three over-riding professional responsibilities with regard to obtaining consent.*

*'To make the care of people their first concern and ensure they gain consent before they begin any treatment or care.*

*'Ensure that the process of establishing consent is rigorous, transparent and demonstrates a clear level of professional accountability.*

*'Accurately record all discussions and decisions relating to obtaining consent.'*

The RCOG and RCM

RCOG Clinical Governance Advice[8] states:

*'Before seeking a woman's consent for a test, treatment, intervention or operation, you should ensure that she understands the nature of the condition for which it is being proposed, its prognosis, likely consequences and the risks of receiving no treatment, as well as any reasonable or accepted alternative treatments. Uncertainties should be discussed.*

It specifically mentions consent for screening tests, ultrasound, caesareans, vaginal examinations and the presence of students. It also says:

*'If consent has to be obtained from a woman during painful labour, such as to perform a vaginal examination, operative delivery or to site an epidural, information should be given between contractions.'*

RCOG produce over 50 guidelines on various conditions and treatments; the full list of available guidelines can be found at www.rcog.org.uk/guidelines

Few of the guidelines mention consent specifically, and again consent was more likely to be included for an invasive procedure. If the argument for its omission is that it is covered elsewhere then we would appeal on the basis of women's experiences for them to reconsider.

For example, on giving Anti-D *'Consent should be obtained and recorded in the case notes.'* (GTG22).

The wording for ECV was interesting and may give an insight into how consent is being viewed, particularly the comment:

*'All women undergoing ECV should be offered detailed information (preferably written) concerning the risks and benefits of the procedure. Consent may also be appropriate.'* (GTG 20a – ECV page 5).

We would hope that no one would actually really consider that consent for ECV was sometimes unnecessary and we assume that what should have been written here was that '*Written consent may also be appropriate'*. It also shows how information is not being used as part of obtaining consent to a procedure as it is advising that the information is given to women 'undergoing' rather than those being offered or considering ECV. Such apparent misunderstanding of the basis for making informed decisions, and providing for informed consent or informed refusal are leading to regular assaults on pregnant women around the country on a daily basis, as to administer treatment or care without valid consent constitutes criminal assault as well as medical negligence.

**treatment or care without valid consent constitutes criminal assault as well as medical negligence**

The RCM also did not seem to have a separate document, but they include discussion of consent in some of their practice guidelines.[9]

It was interesting to see when consent was included and when it was not; again like the NHS and RCOG there was more discussion of consent with invasive procedures. The guidance on vaginal examinations and immediate care of the newborn, both for the examination and the administration of vitamin K explicitly refer to consent being obtained.

However, none of the rest of the guidance, covering such aspects as fetal heart rate monitoring, care of the perineum, supporting women in labour, use of water or the third stage of labour, explicitly consider consent.

Although issues around decision making are discussed in many of the other practice guidelines, there seems to be a significant gap between practice guidance and what is the bottom line in terms of a woman consenting to things being done to her. For example in the guidance on 'Rupturing Membranes in Labour' it does say:

*'The decision to rupture membranes should only be taken in direct consultation with the woman, when the evidence is discussed and the intervention is not minimised. This discussion should form part of the birth plan, and not take place just before or during a vaginal examination.'*

But what it fails to make absolutely clear by not including the issue of consent it that this is the woman's decision and no one else's.

Similarly in the 'Third stage of Labour' guidance it says:

*'Women at low risk of postparum [sic] haemorrhage who request physiological management of the third stage should be supported in their choice.'*

Does this imply that other women do not have the option to reject this intervention? This runs completely contrary to all other guidance on obtaining consent for interventions.

The Law

So legally where do women stand in retaining their autonomy? The courts have been examining the question of consent to medical treatment for 250 years. In the 1950s, the High Court held that the same test should be applied both to the standard of treatment and whether or not there had been a failure to warn the patient of the risks of that treatment – the requisite standard in each case being that recognised as proper by a competent body of professional opinion.[10]

In the 1980s the courts again considered consent. The House of Lords upheld the previous decisions and found that the duty to disclose information and obtain consent was defined by what a reasonable doctor would do rather than what a reasonable patient would expect.[11]

**to harass or bully a woman into giving consent means that the consent is not valid**

Although this caselaw with its paternalistic approach remains the main legal authority on consent, the courts have been more sympathetic to the patient's right to autonomy and dignity when looking at questions around consent more recently. There has been greater recognition of the concept of a 'reasonable patient' who requires information on risks to reach his or her own decisions about treatment. One judge referred to the right of patients *'to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised'* and asserted that *'[t]he court is the final arbiter of what constitutes informed consent.'*[12] However, there is still a lack of certainty and clarity as to how to apply the legal test for whether or not the necessary consent was obtained.

Conclusion

So, overall, there seems to be a fairly clear and consistent approach from Government, institutions, health professionals and the law, one that says that individuals should be provided with accurate and unbiased information and allowed to make their own decision which should be respected regardless of whether the health professionals agree with them or not; and that to harass or bully a woman into giving consent means that the consent is not valid. Yet, in day-to-day practice, women seem to be struggling to retain control over their bodies and their decisions and the dilution of the strength of the second statement by NICE (page 4) with the phrase 'while taking into consideration the clinical situation' may give some insight into how health professionals may be led astray by a belief that they may be in a better position to decide what should happen to a woman.

It seems that although the issue of consent is being considered, there is a lack of clarity about how it should be implemented in the day-to-day practices of our obstetricians and midwives. The experiences of women make it clear that the routines of maternity care are enforced upon women, without women being enabled to provide or decline consent.

For informed consent for any form of care, a woman not only requires information and the chance to provide consent, she needs alternative options to be made fully accessible, she needs to know that she will not be bullied or threatened should she decline routine or preferred treatments or practices and she needs our health professionals to fully support informed refusal as well as informed consent; and for their professional bodies to spell this out clearly in their guidance.

*Debbie Chippington Derrick*

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## Congratulations

The AIMS committee would like to extend huge congratulations to our Journal Editor, Vicki and her family Patrick, Tom, Olivia, Will, Joe and Bob on the birth of Ted. We were delighted that she achieved a peaceful home birth, after her previous pregnancy ended prematurely in a very difficult second caesarean. We all wish Vicki and her family well.

# Who Makes Which Decision?

*Gina Lowdon* talks about the realities of making birth choices

In early March 1992, a little over two weeks after I gave birth to my son at home as I had planned, the Government's Select Committee for Health launched the Winterton Report detailing the results of their enquiry and recommendations on provision of maternity services. Although this was some two decades ago it is significant because it came at the beginning of an era where official documents and general rhetoric have been characterised by the term 'informed choice'.

The in-depth inquiry involving extensive research that resulted in the Winterton Report had been instigated 'by hearing many voices saying that all is not well with the maternity services and that women have needs which are not being met.'[1] Those 'many voices', AIMS among them, welcomed the Winterton Report and were surprised but pleased that the Health Committee was prepared to act on its findings.

## The Illusion of Choice

In due course a further report called Changing Childbirth[2] was published, setting targets for implementation and recommendations for good practice. On page 1 the report said:

*'The Select Committee concluded that a medical model of care should no longer drive the service and that women should be given unbiased information and an opportunity for choice in the type of maternity care they receive, including the option, previously largely denied to them, of having their babies at home or in small maternity units.'*

Unfortunately the flaw in this recommendation was, and still is, that childbirth is now predominantly seen as a medical event and service provision is therefore driven by the dictates of the medical model of care. Options for birthing at home or in small maternity units where medical concerns have considerably less relevance therefore have a very low priority within the NHS which is, of course, primarily concerned with providing medical care.

Women can only readily choose from options which are made available to them and the choices available are dictated by the medical establishment which controls funding for maternity service provision and which decides which options are appropriate and will therefore be provided. The way choice is restricted was explained by Beverley Beech in her book Who's Having Your Baby?[3]

*'Martin Richards (a psychologist) illustrated perfectly the way in which choice is restricted by describing how a woman walked into her local supermarket and asked the manager what choice of fish was available, "Well, we have whiting, herring, sole, plaice, mackerel, cod and rock salmon." She said, "How wonderful. Is it fresh fish?" "No," he replied. "We only sell frozen." The woman had a choice, either to go away empty handed or reluctantly accept some frozen fish. To her there had been no choice, but as far as the manager was concerned he had offered her a whole range."*

Thus women's choice of care options is limited by an establishment focused on the provision of medical care. One might as well seek to buy fish from a butcher.

The idea that the NHS Maternity Services should be providing non-medical options for birth has never really been understood or taken on board by the medical establishment, which currently is the only provider of state funded maternity care. Birth is widely acknowledged as being a time of great risk, a condition requiring careful monitoring in order to catch problems early or even before they have occurred. Whilst all interventions can safeguard health or life when used judiciously, very few people are aware that many of the problems that do arise are the result of inappropriate and overuse of technological and medical treatments. Much of the damage to women is iatrogenic and evidence clearly shows that a less medicalised approach leads to better outcomes.[4]

Unfortunately, the notion that the vast majority of babies (around 95%[4]) could be born without problem is inconceivable, despite research evidence that this should be achievable.

The difficulty the medical establishment has in reconciling the idea of non-medical birth with medical service provision is illustrated by the following 'Key message' from the RCOG Expert Advisory Group Report (July 2011):[5]

*'While choice is supported in principle, there is a need to be mindful that choice has to be delivered in a realistic manner, balancing wants and needs with what is clinically safe and affordable and what resources can be made available without destabilising other services.'*

**there is the underlying suggestion that women may not be trusted**

So 'choice' is all well and good … within reason. There is the not so subtle suggestion that what some women might want may be contrary to what they need, might be deemed clinically unsafe and may be considered unreasonable in terms of service provision. Clearly there is the underlying suggestion that women may not be trusted to make responsible choices, therefore those choices must be limited to those deemed 'appropriate' and which the medical establishment, focused on pathology, consider it reasonable to provide.

This conflict is further illustrated in the RCOG Report's Introduction:[5]

*'Care should be personalised, ensuring risk assessment, continuity of care and choice (this may be influenced by safety and availability of services.)'*

Again there is the inference that good non-medical care can be unsafe in some way and that there are logical reasons why it might not be reasonable to make it universally available. Clearly, despite all the rhetoric, there are considerable barriers to providing women with real 'informed choice'.

Most people within our society have been convinced by the medical establishment that all improvements in outcomes are due to advances in medical care and technical developments, making it difficult to even consider declining all that is on offer, regardless of what the research indicates about effectiveness and risks. Women who do express a preference for non-medical birth options rarely encounter a favourable response.

Define 'Informed'

The maternity services therefore, content in their mistaken conviction that all that is reasonable is being done to provide a full range of appropriate maternity care options, have a tendency to focus on the 'informed' element of 'informed choice'. Since, from their perspective, the range of choices is clearly not an issue, then surely if women were properly informed they would be choosing the form of care deemed most appropriate by knowledgeable and experienced professional health carers? After all, everyone wants the same outcome, don't they?

## everyone wants the same outcome don't they?

As far as the maternity services are concerned women making what are deemed to be inadvisable choices must therefore either be irresponsible or ill-informed.

Around the time that Nicholas Winterton's Health Committee was conducting its inquiry, research was becoming more accessible to lay organisations. Women became aware that many of the inadequacies they saw in maternity services provision, and their views on how these could be rectified, were, in fact, supported by medical research. The gap between the evidence base and general practice became evident and led to calls for evidence-based practice which, quite rightly, persist to this day.

This is all well and good, but there is a hierarchy when it comes to research evidence. Research results can be divided into 'quantitative' data (information that can be measured by numbers), and 'qualitative' data (information that is descriptive and therefore more difficult to measure.) Sometimes qualitative data is defined closely so that it can be converted into numbers for outcome statistics, but this often results in a loss of the non-measurable bits of the data.

Topping this hierarchy is the RCT (Randomised Controlled Trial), which is generally focused on outcomes in terms of numbers; the larger the number of participants the better, especially when looking at statistical differences for rare outcomes. Bringing up the rear are the case histories, which bring a richness of detail (qualitative data) but which apply to either very small groups or the lowest number possible, one.

## Women value qualitative research

This means that outcomes such as maternal death or length of hospital stay, which can be measured in numbers, are easier and cheaper to collect and assess and less subject to bias than qualitative data such as levels of pain or women's satisfaction with the service provided, which can be difficult and time consuming to collect reliably and are more open to biases of interpretation. For these reasons 'quantitative' data is considered to carry more weight that 'qualitative' data.

Evidence-based medical practice has now come to rely heavily on official guidelines and hospital protocols. Due to the sheer volume and complexity of research that is now currently available, guidelines and protocols tend to focus predominantly on studies from the top of the hierarchy, particularly if these are large enough to show statistically significant differences for rare conditions relevant to planning maternity service provision for populations. This means that the experiential, qualitative evidence which is of interest to women is sidelined.

If there is a high quality, large RCT on any given issue it is likely to be considered sufficient evidence base and therefore inclusion of other studies may be considered unnecessary whether the findings of the RCT are supported or not. Also, studies further down the hierarchy may not be considered sufficiently 'robust' for inclusion, despite the often valuable insights and pause for thought that they can provide.

An additional limitation of research studies is that many are restricted to short term outcomes and tend to focus on serious adverse outcomes or benefits, either ignoring or placing less importance on more common adverse effects or benefits, some of which may have serious later consequences. Whilst the medical establishment is understandably focused on provision of maternity services for whole populations, it can be argued that the research base used is simplistic in its concentration on large numbers and rare outcomes.

In contrast, the concerns of individual women cover a much wider range of issues including common outcomes that have a much greater chance of affecting them personally. The extent to which the medical profession

are prepared to subject huge numbers of women to risks of 'minor' adverse outcomes in order to save a tiny number of women and/or babies from rarer but much more serious adverse outcomes is extremely worrying.

The term 'research-based' gives the impression of being inclusive of all research on a given issue, but unfortunately in reality the research base used has become much more selective and heavily weighted towards the much narrower, predominantly quantitative and limited, range of outcomes of interest to health professionals. It is research based, but it does not take account of all the research information available on any given issue. It also ignores any common knowledge that is 'known' but unproven by robust research.

Women are rarely reliant solely on the maternity services for their information. Women share experiences and knowledge gleaned from friends, relatives, social networks and the internet and consider their personal needs in the much wider context of their whole life situation. The health of their baby is of course of paramount importance, but women also take many other aspects of birth and life into account.

Non-medical aspects of birth are of great importance to women but unfortunately the maternity services pay little more than lip service to them if they consider them at all. These include such care aspects as the benefits of home birth, the advantages of waiting for labour to start spontaneously, the reassurance of having one-to-one care from a known and trusted midwife, the comfort of being able to move freely in labour and adopt instinctive positions for birth, the care of older siblings, feelings of safety, respect and autonomy that go far beyond and yet still encompass the physical safety of the baby which can all too often seem to be the sole concern of the medical establishment.

## It is clear that women do not have real freedom to make 'informed choices'

It is clear that women do not have real freedom to make 'informed choices'. Not only are they expected to make choices from a medically controlled menu of options, they are supposed to base those choices on an artificially narrow information base deemed worthy by the medical establishment.

Just as medical influences are restricting 'choice' so too are medical opinions having an effect not only on the way women are 'informed', but also the level of respect accorded to how they are informed and the sources of their information.

### Is it a Choice or a Decision?

Whilst there is no doubt that women should have a range of options, backed up with good information, from which to make informed choices regarding their maternity care, the phrase itself confers a power balance in favour of the medical establishment; it belies the legal reality that women are entitled to make autonomous decisions regarding the care they will accept or decline.

Equally women are entitled to make decisions whether they are considered by others to be 'informed' or not; to base their decisions on whatever information base they feel most relevant to their individual circumstances; or indeed, to make decisions based purely on 'gut instinct'.

A woman's right to make decisions regarding her care is NOT, contrary to popular belief, affected by the existence or absence of any medical condition or obstetric history. Women with medical conditions tend to be much less likely to question the medical advice they have been given, but their right to do so remains.

Women are entitled to make decisions rather than choices and they do not have to justify those decisions.

## obstetricians make decisions and women make choices

### Who makes which Decision?

Unfortunately the Maternity Services are operating on the basis that obstetricians make decisions and women make choices.

Obstetricians do have decisions to make of course; they have an obligation to assess evidence and use their professional experience to make carefully considered Clinical Decisions over what forms of treatment or care should be offered to pregnant and birthing women. However, having come to a Clinical Decision, and having advised the woman accordingly, it is then entirely up to the woman to make a Personal Autonomous Decision to either accept or decline what has been advised, regardless of the potential consequences.

The majority of women, however, are unaware that they have a decision to make. This is clearly illustrated by women with a history of caesarean section who want to give birth vaginally to their next baby; many are under the mistaken impression that they need the permission of an obstetrician to labour and give birth to the baby they are carrying – is it not ludicrous to make women feel they require permission to give birth?

Indeed, when a woman is healthy and has enjoyed a problem-free pregnancy it can be argued that there is no clinical decision to be made. However, since most women tend to go with the flow of medical advice, albeit in many instances much against their better judgement, those few women who do make Personal Decisions that are not in line with medical opinion are more often than not met with perplexity, incredulity and pressure to conform.

### The Validity of Consent

The aforementioned issues concerning 'choice', 'informed', and 'who makes which decision' impact very seriously on the validity of 'Informed Consent' and it is clear that the understanding of many health professionals leaves a lot to be desired.

The NHS Maternity Services, in common with all areas of the NHS, has a legal obligation to offer patients what is considered to be appropriate medical care. Patients then have the legal right to either accept or decline the treatment or care that has been offered. Where the vast majority of cases are concerned, patients are ill or are suffering from some medical problem, so consent issues are possibly less controversial since patients are generally anxious to recover good health, have consulted their doctor in the hope of a remedy and are keen to try any treatments offered, and the sooner the better.

The Maternity Services present a slightly different scenario, since for the most part women are healthy and most pregnancies are straightforward showing no signs of medical problems. Many of the treatments that are commonplace do not deal with ill health, since normal pregnancy is a sign of good health, not ill heath, and generally consist of monitoring procedures which are not designed to safeguard health but to detect ill health or deviation from what is considered to be the norm.

Valid consent is therefore particularly important within the Maternity Services since women have firstly not approached their doctor with a medical condition and secondly are usually healthy individuals who are being 'offered' treatments and forms of care which may not be clearly indicated by a currently presenting problem and therefore carry the risk of adverse effects without any compensating benefits to the individual. This was further illustrated by the recent Birthplace Study,[6] the latest in a long line of research indicating the increased risks to women and babies of birth in hospital.

We are now at the point where

- non-medical options for birth are thin on the ground within the medically-oriented NHS,
- women are being pressured to 'choose' between limited care options which are medically-managed and therefore inappropriate for predominantly healthy women,
- birthing decisions are expected to be based on narrow, carefully selected research focused mainly on short-term medical outcomes which may or may not be relevant to the woman's individual case,
- refusal of consent is not considered valid if it is not in line with medical expectations,
- birthing decisions are seen as the domain of obstetricians, not women.

The consequences are dire: high rates of intervention, high rates of avoidable caesarean sections, higher costs to the NHS,[6] high rates of post birth trauma, suicide now a leading cause of maternal death, low rates of 'normal' physiological birth, low rates of breastfeeding, adverse effects on bonding and parenting skills to list but a few.

And yet the evidence is clear about what needs to be done, so why are we no further forward two decades on from Changing Childbirth?[2]

Who is making the decisions? In theory women have the right to make decisions or at the very least informed choices from a full range of birthing options. In practice decisions are dictated by an obstetric-led maternity service that limits options available and controls freedom of choice. Women, even healthy women, are captive patients who must either comply or fight a continual battle throughout their pregnancy in order to retain any semblance of autonomy.

It is not good, and it is getting worse.

*Gina Lowdon*

**carry the risk of adverse effects without any compensating benefits to the individual**

Women making valid decisions to either decline professionally recommended care or who require access to birth options not 'on offer' through their local maternity services, especially if they are basing those decisions on valid grounds albeit not grounds considered worthy, are increasingly finding themselves the subject of harassment, bullying tactics, and accusations that they are putting their babies at risk to the extent that in an increasing number of cases inappropriate and damaging referrals to Social Services are being made.

### Further Reading

www.kingsfund.org.uk/blog/decisionmaking.html
Please stop muddling shared decision-making and provide choice by Angela Coulter, 1 June 2012, with interesting following comments.

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# Beware the Dead Baby Card...

*Johanne Dagustun* reveals that it is not always played in the baby's best interests

Call me naive if you wish, but I was shocked to come across some persuasive evidence that 'playing the dead baby card' is an acknowledged and accepted part of medical culture, used to gain control over childbirth decision-making, even where the healthcare professional sees no risk to the baby's life.

The evidence I found to suggest this murky side of the maternity care service's particular form of 'management by shroud waving' is tucked away in a scholarly article reporting on some new research. This research focuses on how Canadian pregnant women and care providers manage birth in the context of a highly medicalised culture of childbirth.[1] High rates of caesarean section, induction and EFM are as common in Canada as across much of the developed world. The article concludes that there are huge pressures on the part of everyone concerned with childbirth to accept surveillance and interventions 'in a risk-averse culture'. But as ever with qualitative research, it is in the detail of the report that important cultural norms are revealed.

For the study, Wendy Hall and her fellow researchers ran a series of focus groups across five Canadian cities, each comprising a variety of healthcare practitioners and first-time pregnant women, to help shed light on the question of how such a high-intervention childbirth culture is continually re-created as a result of the everyday actions of both healthcare practitioners and pregnant women as they go about seeking to manage labour and birth. Identifying how all participants seemed to be explaining their actions in terms of 'minimising risk whilst maximising integrity', which of course plays out in different ways for different participants, the researchers stumble across what struck me as a very honest account of the 'dead baby card' phenomenon:

*'Care providers who relied on surveillance, interventions, and plotting courses that emphasised risk were more likely to exert their control and feel strong through minimising women's power and control and, ultimately, their integrity. Some care providers talked about "pulling the dead-baby card" when their need for control and power was more important than women's control, whether or not the baby was at risk:*

*'I've heard that. "Well, you don't want your baby to die, do you?" We call it pulling the dead-baby card. We really want you to do this thing ... Some were for things that were not life-or-death situations.'*

Wow!

Whilst researching contemporary UK childbirth culture, I often find that I have lost my ability to be shocked – too often I seem to adopt a position of weary acceptance at such information, but after a pause for thought, this passage really brought me up short.

Perhaps you have personally witnessed this 'dead baby card' phenomenon? If not, you may have heard about it second-hand, given its frequent citing on a number of online birth support groups. I must admit that I was a little sceptical of both its existence and seemingly huge power until I consciously experienced it for the second time last summer, when I witnessed an obstetrician using it quite overtly, in a way which made little sense to me at the time. In that case, notwithstanding its apparent incongruity with the situation at hand, I certainly felt the technique's power. It quite chillingly triggered its intended effect. Highly efficiently, it immediately seemed to silence the pregnant woman concerned, ensuring that complete responsibility for decision-making about her baby's birth was handed over to the medical team.

Some of you will be aware of the debate about this 'dead baby card' technique which is currently underway in the blogosphere, which links into a broader debate between 'pro- and anti- natural birth proponents'. This debate has inevitably included the voices of some bereaved parents, who make an impassioned case for not dismissing 'the dead baby card'. Parents who have lived through a harrowing experience of losing their baby often make for thoughtful advocates of medical intervention, of course, and it is important to pay heed to their stories. But nowhere before – and certainly not in this blogosphere debate – have I seen the suggestion that the 'dead baby card' is played in cases where the obstetrician doesn't honestly feel that there is real danger if their recommended care pathway isn't followed. Thanks to Wendy and her fellow researchers, this murky truth about the techniques used by healthcare professionals to assert control over the birth process has now been well and truly revealed. So much for the rhetoric of woman-centred care, informed choice or shared decision-making.

So what? For me, this is a call to action. It validates yet again the role of organisations such as AIMS, which seek to support prospective parents who encounter the 'dead baby card' in the course of their routine maternity 'care'. Hard as it might be (and I know it is), we need to support a more authentic process of communication when 'the dead baby card' is played, for example one in which all concerned feel able to stay calm and request a straightforward account of the rationale for the healthcare practitioner's recommended course of intervention. Only when we are truly persuaded that the situation would benefit from intervention (which will inevitably disturb the wonderfully intricate and sophisticated physiology of childbirth) should we let the medical team proceed.

*Johanne Dagustun*

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# Violence in Venezuela

*Elizabeth Prochaska* looks at ground-breaking laws protecting the rights of women

South America is notorious for its astronomical rates of caesarean sections. It is less well-known for pioneering human rights laws. But obstetrics and human rights have collided in a remarkable new law passed in Venezuela in 2010 criminalising 'obstetric violence'. It is described in an editorial published in the International Journal of Gynecology and Obstetrics by Dr Rogelio Pérez D'Gregorio, a Venezuelan obstetrician. Obstetric violence is defined in the 'Organic Law on the Right of Women to a Life Free of Violence' as:

*'...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.'*

It then lists specific obstetric acts that constitute obstetric violence, including forcing the woman to give birth in a supine position and using acceleration techniques and performing caesarean sections without obtaining 'voluntary, expressed and informed consent' of the woman. Healthcare professionals found guilty of obstretric violence are liable to a fine and will be referred to their disciplinary body.

Dr D'Gregorio does not say if anyone has yet been prosecuted for obstetric violence, but regardless of whether the new law is being widely applied, it is a very powerful social statement that endorses birthing women's autonomy. It is rare that unwanted interventions in childbirth are characterised as violent (as opposed to traumatic or merely unpleasant), but that is, of course, how many women experience them and it is very encouraging to see the term enter the legal lexicon. Crucially, the Venezuelan definition of obstetric violence recognises that the choices women make in a medicalised system may not be freely and properly informed. They may be made under the influence of veiled threats about the safety of their child, or in response to a limited range of options presented by a doctor with a vested interest in a particular outcome. As the Venezuelan law suggests, an expansive understanding of the concept of consent needs to be adopted to address these concerns.

Dr D'Gregorio accepts that the law is appropriate in Venezuela where natural childbirth is a rarity and there is an acute problem with caesareans performed without consent. Would such a law be useful in the UK? Certainly the lack of civil litigation challenging unnecessary caesareans suggests that a culture shift needs to take place in how the law (and lawyers) perceive women's rights in childbirth, but it must be hoped that change here can be achieved without criminalising medical professionals.

*Elizabeth Prochaska*

# Spanish Rights

Of Birth, Spanish Obstetricians, bad jokes and roses by *Jesusa Ricoy-Olariaga*

I am a Spanish woman who has been living in the UK for as long as I lived in my own country (18 years). I am a mother of three, a doula and childbirth educator. Occasionally I train doulas and other professionals in Spain and I founded a network modelled on Sheila Kitzinger's Birth Crisis Network (I also volunteer for BCN). Over the years I have developed a social network of Spaniards who are either involved in birth or simply support a more progressive approach than the one which seems to be the norm.

When I talk to fellow Spaniards I sometimes feel as if I am in the movie 'Back To The Future', explaining to people in the 1950s how life will be thirty years later. I tell them that doulas are present at births in the UK, unlike in Spain where they can act only in a postnatal capacity, pretend to be a member of the family or wait outside the labour room entirely.

I tell them about my lovely team of midwives at my home births, paid for by the NHS.

In Spain home birth care is private. You have to pay for independent midwives or obstetricians, and they are not widely available. Even if you manage to find care, if you end up needing hospital assistance for any reason most likely the care given to you will include retaliation against you for having had such silly ideas in the first place. Like a runaway having to come home because they've run out of money only to be punished.

I know things in the UK are far from perfect – I disagree with offering sweeps at 40 weeks, for example – but in Spain, most of the time there is no choice; they just do a sweep without even telling you. I'm sure there must be competent professionals who do their job properly in the country of my birth, but recently I've really begun to wonder.

In Spain we have a 90% episiotomy rate, a caesarean section rate of around 22% in public hospitals and 32% in private ones, and we don't even know the statistics for the use of forceps or ventouse because they're not recorded (the lack of data and transparency is a major problem). Women are often verbally and physically abused by their obstetricians and Kristeller's manoeuvre (fundal pressure) is a common practice, yet never recorded in the notes. In Spain it's either epidural or nothing (epidural rates are currently around the 80% mark) and women are still systematically shaved and given an enema in most hospitals.

On top of all that, we've now discovered that instead of trying to improve birth and the care of women, obstetricians and gynaecologists are laughing at us.

Overleaf are four of a series of 21 cartoons that the Spanish organisation El Parto es Nuestro publicly complained about in the second week of September 2011. They were drawn by a gynaecologist member of SEGO (Spanish Society of Gynaecology and Obstetrics) and published in La Gaceta, the professional journal of SEGO, for everyone to see online.

The cartoons poke fun at prolapses, incontinence, STIs, non-medicalised birth, babies and it seems all women in general. They even joke about approaching attractive patients in a sexual manner. The cartoons portray women as largely illiterate and the doctors as men.

You think this is bad? Some of us thought so too. So I opened a Facebook group and started campaigning. Soon we had over a thousand people getting together, signing petitions and generating ideas.

I proposed using roses as a symbol to represent women, and with the wonderful creativity and talent of the people in the group we created a logo for our campaign. We called it The Roses Revolution: a movement against obstetric violence, and had quickly organised some actions and demonstrations in several Spanish cities.

From my point of view things were bad, but what was horrific, and still is as I write this piece, was the silence. The silence of midwives, of student midwives, of female gynaecologists and obstetricians, of women medical professionals in general who work with, or as part of, SEGO. Only a few have spoken out, so few I can literally count them on one hand. On top of that, in the few media outlets who touched on the story, the comments were shocking.

We received even nastier and more degrading insults from women unconnected with SEGO or the medical establishment in general, who insisted that the whole debate was based on a sense of humour. Even a well known author and paediatrician, who many women respect for his approach to breastfeeding, stated in an online interview that there was no need for all the fuss and that he wouldn't want to live in a country where his freedom of speech was reduced in any way. We were, on many occasions, in various online publications, called 'Feminazis'.

Meanwhile, where were Dr Josep Lailla, President of SEGO, or Dr Server, gynaecologist and part-time cartoonist?

Well, the former stated in a radio interview that the whole thing was just a bit of a joke and that he was shocked and displeased with the reactions they'd received. When under pressure from the Ministry of Health, Gender Equity and Social Affairs, he stated that they were going to 'analyse the comic strip' to see what could have caused such upset. This analysis must be more in-depth than expected, because there still hasn't been any apology, and although the cartoons have been removed from SEGO's website they have been frequently reprinted. As for the latter, Dr Server, he won't speak without his lawyer.

It really feels to me that many women in Spain are being systematically and institutionally abused and nobody cares. Yet more women inadvertently defend the abuse because they believe it's a necessary part of the process.

You think I'm exaggerating?

I created a page for women who could not actively participate in our various actions and demonstrations, in order to document the horror many of us go through at the hands of medical professionals in Spain. This quickly filled up with a litany of abuse.

One women stated that, 'They immobilised my hands so that I couldn't move during the placenta extraction.'

Another older woman, a widow, claimed that when going for a vaginal examination the doctor exclaimed, 'Gracious me! You have cobwebs up here!'

And it gets worse. Yet another wrote:

*'I was told off for not coming earlier with the first contractions. They said that my waters were leaking so it would be my fault if the baby died of sepsis. I was forbidden to move from the bed for 10 hours. They insisted more than 15 times that I needed an enema. They did eight vaginal examinations without asking for permission. A plumber arrived to carry out some work without my consent. There were mistakes in the monitoring of my baby's heartbeat. They were actually taking my pulse from my thigh. I had to insist and insist for them to double-check as one of the midwives was ready to go for caesarean section. They never answered any of my questions. The effect of the epidural (which I requested for the lack of mobility and resultant pain) wore off before they performed the episiotomy, so forceps and stitching was done without any anaesthetic. My baby was eventually passed over me for about two seconds before they took him away again. I even had to put up with comments such as, "We don't do natural birth here, we do managed birth" and "How I wish they all birthed weekdays between 8am and 6pm" said within my presence as if I wasn't even there.'*

It is an utterly devastating picture for me as a very passionate birth activist, as a mum, as a doula, and a Spaniard, one who feels very 'lucky' to have given birth at home in London.

I wish, hope and fight for the day where giving birth is not a matter of luck, but a matter of respect.

However, I know that this respect also has to come from the women in a society, where demanding an end to brutality against our bodies is perceived as 'feminazism'. Where even highly respected and intelligent professionals consider these horrendous attacks from the doctors who handle the most sensitive and emotional parts of our bodies to be simply freedom of expression.

It's not going to be an easy task and I think this issue is serious enough that it should be considered by EU regulatory bodies. We simply cannot tolerate, in a so-called civilised society, for women to continue suffering mutilation of their bodies and genitalia. In a country with a 90% per cent episiotomy rate this is institutionalised mutilation.

We cannot raise a healthy society if so many of the population are damaged by their birth or believe that birth means horrific torture and exposure to abuse.

There is nothing else to call it: it is violence and abuse.

So it is time to say 'No more!'

I just hope the message will travel far and the pressure on Spain will grow. I hope this for my friends, for their daughters, for the genuine professionals and for all women everywhere.

*Jesusa Ricoy-Olariaga*
*www.birthinglove.co.uk*
*www.larevoluciondelasrosas.blogspot.co.uk*


Quick ... call the pediatri... the geriatrics team!
We have another prolonged pregnancy!!


Quick, put him back, she hasn't signed the consent form!


A smear every three years? How strange!!...
My gynecologist does it every three months...


Maybe it's me, but seeing this pessary, I'd have preferred surgery ...

# Testing Consent

*Amanda Dixon* asks looks at routine testing and information given

Is informed consent a thing of the past? Is it another one of those things that is being lost in the issues of time constraints of appointments or getting lost in the vast amounts of 'information' being given to women at the first appointment?

When I worked as a midwife I had it instilled in me that women needed to be totally sure about what we were asking to do and why. I would spend a deal of time discussing the issues of screening, what we were screening for, how and why and asking questions: 'Are you happy for this? Do you need more time to think about it? Is there anything further you want to ask? Remember these are offers of screening and you can opt out of any of these tests – do you wish to opt out?' I am now becoming worried that with the all pressures in the system of appointments on time, the fact that screening is being done earlier and earlier in pregnancy that women just aren't getting enough information. Why am I worried?

I, am amongst other things, a member of the Independent Placenta Encapsulation Network, offering placenta encapsulation and other placenta services. Part of the booking process for these services is to ask if the woman has been tested for HIV or for Hepatitis, and if the results were positive or negative.

I seem to have an increasing number of women who tick the box on the booking form saying they have not been tested for these things. At this point I always ring the woman to discuss. On further questioning they have all had the routine blood screening at the beginning of their pregnancy and had not been aware that these were some of the things they were being tested for. When planning on handling a placenta it is important I have this information and if a woman is HIV or Hepatitis positive then I can't risk my equipment getting contaminated (even though I always use universal precautions and approved cleaning methods). I am shocked that out of the women who have ticked to say not tested, 100% had not declined routine blood testing and had had the full remit of blood screening, having no idea what they were being tested for. They have all apologised to me for not realising that they had therefore been tested. They do not need to apologise to anyone – someone should be apologising to them. The conversation then moves to the 'Well I am sure I must be negative then, as they would have told me otherwise … wouldn't they?'

I am horrified that women are being tested for infections, that if positive can have huge implications for their future lives, with what appears to be a total disregard for the impact this may have and no regard for the concept of informed consent. This is not an isolated case, or from an isolated hospital. Surely someone needs to be saying something. I feel that women really are not truly being given all the information, but are being railroaded into following the process with limited information and limited choice. It makes me wonder if this is just the tip of the iceberg with regard to informed consent within the current NHS.

*Amanda Dixon*
*Lotus Doula*

# Government Promises – May 2012

The Government has pledged to improve maternity care by:

- Making sure the investment in a record 5,000 midwives currently in training means that women will have one named midwife who will oversee their care during pregnancy and after they have had their baby.
- Making sure that investment also means that every woman has one-to-one midwife care during labour and birth.
- Making sure that investment means parents-to-be will get the best choice about where and how they give birth. The Government wants to see more joined up working so women can choose from a full range of services, meaning that choices made are delivered within an integrated, flexible service.
- Providing an additional 4,200 health visitors to provide better support for women who have postnatal depression or who have suffered a miscarriage, stillbirth or the death of a baby.

The full document is available at:
mediacentre.dh.gov.uk/2012/05/16/nhs-pledges-more-support-for-women-with-postnatal-depression/

AIMS comment:

Is this a way of 'promoting' the 'enhanced' role that Health Visitors will have, or will it genuinely mean that women who have depression postnatally get access to specialised psychological services instead of more monitoring, surveillance and reporting to Social Services?

This sounds good on the surface, but with each clinical commissioning group (CCG) free to decide how much to invest in maternity care and how many midwives to employ, it is difficult to see how the Government can make sweeping pledges that will have a national impact.

# Human Rights in Childbirth

International Conference of Jurists, Midwives and Obstetricians. June 2012, The Hague

Five members of the AIMS Committee made the journey to The Hague for this historic conference, full of high expectations, we were not disappointed in any way. Lawyers, midwives and childbirth activists gathered to discuss the role of the law in birth and maternity services.

One of the main triggers was the case of Ternovsky v Hungary, which established the human right of a woman to choose the circumstances in which she will give birth. The case is binding across all European states and arose out of the wish of Anna Ternovsky to have her second baby at home, attended again by the midwife Agnes Geréb. Realising that Agnes Geréb was being persecuted for the crime of assisting women to give birth at home, she took her case to the European Court of Human Rights in Strasbourg and won. The court condemned the state of Hungarian birth policies and ordered the country to create the necessary regulations as soon as possible. Anna was with us at the conference and spoke movingly of her two births at home and her dismay when Agnes Geréb was later imprisoned.

Elizabeth Prochaska, a barrister from Matrix Chambers in London, underlined the importance of this legal precedent; the UK government could be fined for failing to respect a woman's right to determine the circumstances in which she gives birth, so we need to take our cases to the British Courts under Article 8, Respect for Family Life. Elizabeth has already worked with AIMS to successfully mount a legal challenge to an NHS Trust in London which withdrew its home birth service. In the Autumn of 2012 she will launch the organisation Birthrights, to offer help to women being denied their human rights.

The other main focus of the conference was the potential conflict between the interests of mother and unborn baby. In fact, in most people's minds, and indeed in English law and the law of many other counties, the interests of mother and baby are indivisible before birth (unless the mother clearly lacks mental capacity) and so, in that sense, the fetus has no independent rights. However, there was agreement that the world is becoming more 'fetus-centric' (perhaps because of the belief that life can be sustained outside the womb and so the mother is only a temporary container) and presentations from around the world illustrated the range of interpretation of this.

Two contrasting accounts, by Ina May Gaskin from the USA and Karen Guilliland from New Zealand, highlighted different approaches to the human rights of women. Summarising the situation in the USA, Ina May has seen caesarean section rates rise from 5% in1970 to 33% nationally, while at the same time, in California, maternal mortality has tripled in the decade between 1996 and 2006. The USA is one of the four countries in the world where maternal mortality is increasing whilst at the same time the rights of the unborn child are put forward in ways that can criminalise women whose decisions and behaviours are questioned by the medical establishment. In New Zealand, where by 2020 most women giving birth will be of Maori, Pacific or Asian origin, women are accorded their human rights and babies have none before birth. This is not law but, in Karen's view, the result of the women's movement. In a population similar to Wales, (4 million), there are 52 small birthing units and midwives' pay is broadly the same as doctors' (although obstetricians can charge for extras as well). Women have whomever they want with them and midwives can be self- employed and enjoy the power of partnership. Karen put the point strongly that our argument is *'no longer about data, it's about safety in a different way, we must talk up midwifery skills not just crude surgery.'* She urges midwives to insure themselves, get together across Europe, and 'grow' their own lawyers, alongside a system of no fault compensation.

Robbie Davis-Floyd, a medical anthropologist from the USA, talked of the emergence of the post-modern midwife, describing her as an autonomous practitioner dedicated to the midwifery model, a vision of political awareness, with an investment in women's emotional needs. Robbie shared a vision where the post-modern midwife is in place of the modern midwife, described as a technician in the medical model. Robbie praised the Albany midwives as heroes, causing much applause. Becky Reed, from the Albany practice, then spoke with great feeling about her philosophy and present situation.

The second day of the conference looked particularly at the state of midwifery in the Netherlands, where home birth rates have been the envy of the western world. We learned that the 30% home birth rate of the 1980s and 90s is now down to 23%; rates of caesarean section are up to 16% (still the lowest in the developed world) and that during this time caseloads had reached 110 (although they are now down to 90). Perinatal mortality rates have been worryingly high around 2004 (but calculated from 22 weeks, when babies are not routinely resuscitated before 25 weeks) but now have reduced to probably the lowest in Europe aside from Finland.

The picture of over-stretched midwives losing autonomy; obstetricians, who used to champion the Dutch system, finding their status becoming dependent on international research, moving from being the colleagues of midwives to being their supervisors; coupled with women working long hours outside the home and becoming more fearful of childbirth, is a familiar one across much of Europe.

My highlight of the conference was to be part of a gathering which asserted vigorously the inalienable rights of a woman to control what others do to her body and to resist blackmail and bullying by others who claim to know better than she what are the interests of her unborn baby: I certainly won't look back.

*Gill Boden*

# Brazelton Meeting

Royal Society of Medicine – 8 March 2012

Brazelton came to my attention in the 1970s when he described the effect babies' behaviour and activities had on the parents and how the parents reacted. He developed the Brazelton Neonatal Behavioural Assessment Scale(NBAS) designed to assess the responses of the newborn and is used in examinations of the newborn up to two months old.

Berry Brazelton described how he developed the scale in 1955 when none in the medical profession would believe that infants could see and hear. He found that babies have different expressions when they look at an object from when they look at a human face and if he stood on one side of the baby with the father on the other the baby will choose the father's voice. He also pointed out that babies develop in spurts and just before they have a spurt they regress and then shoot forward, this can be a difficult time for mothers.

The objective of the NBAS is to help parents read their baby's behaviour, empower them and help them to communicate and change parent/infant behaviour. A video showed a woman who had not held her baby since giving birth and who was distant from the baby. As the video progressed the woman began to respond to the baby and by the time it had finished she was cradling it. At no time did the psychologist instruct the woman but said such things as, 'what a beautiful, strong, baby, look how he pushes his feet against me ... see how he looks for you, he loves his mummy ... how do you hold your baby, cradled in your arms, or on your shoulder?' The woman chose. She did a test where she held the baby between them and then spoke to the baby and asked the woman to talk to her baby too, and when she did the baby immediately turned its head. 'Look, he knows his mummy, he wants to be with his mummy.'

Susan Pawlby a research psychologist spoke about her studies of depressed and psychotic women and the effects of antenatal depression on the biology of pregnancy, outcomes for the mother and baby. The study is ongoing but they have observed that the babies of depressed mothers are less alert, and showed how they were less engaged with a rattle, they were more irritable and were less able to regulate their state. She commented that they can tell by two weeks of age if the mother is depressed, they observe how the mother will be distant but then leap at the baby and overwhelm him - the baby will then withdraw because it cannot cope with the sudden rush of activity.

After the break, we watched a video demonstrating how a baby can be embarrassed, how they respond to a mirror and demonstrated how a baby can anticipate what the mother is about to do, the example involved a two month old on a pressure mat and as the mother approached to lift the baby up, the baby began to arch his back. At seven to eight months they will copy behaviour and can tease. She showed a very funny video of a toddler who was engrossed with a piece of household equipment but heard her grandmother snoring. She turned, was rooted to the spot, but then pulled her cheeks in and copied grannies' snore. Everyone laughed, but the family got a bit bored with it after a while as the child kept on doing it to get a laugh.

A survey of the courses in Poland using the NBAS to prepare parents to care for their babies, found that the parents felt better prepared, more competent, more knowledgeable. She works in co-operation with midwives who select families whom they think will have problems and parents have commented that *'infants' behaviour is no longer meaningless for them'*.

Presentations were made highlighting the areas where training of midwives and health visitors have been introduced successfully. Tameside and Glossop Early Attachment Service has trained 63 midwives and health visitors to intervene early and truly support those struggling with attachment and who are having emotional difficulties.

I came away from the conference thinking that this system should be standard for everyone who has contact with mothers and small babies, what a difference it would make. Instead of criticising, monitoring and ticking the boxes they could actually be empowering and respecting parents.

*Beverley A Lawrence Beech*

## Hand over your rights...

It is a sad reflection on maternity care that women are so disempowered they believe it is in their best interests to submit to what ever is on offer.

On a Facebook forum, a women stated that once you enter a hospital you are and should be under their authority. They [the hospital] should be allowed to do what they want with you and/or your child, especially if you want to ensure safety. A lot of other women agreed with her!

Women should not have to decide between giving up rights and getting treatment. We appeal to all health professionals to empower women to make their own decisions.

# MAMA Conference

Troon – April 2012

What a privilege to spend time with and listen to some of the most incredible and inspirational people in the world of birth.

Speakers included:

- Michel Odent
- Ina May Gaskin
- Denis Walsh
- Kerstin Uvnas Moberg
- Sheena Byrom
- Joy Horner (Independent Midwife)
- Geraldine Butcher (Consultant Midwife)
- Cassy McNamara (Independent Midwife)
- Helen Ball (Professor of Anthropology)

So, firstly, let me say a word of thanks to Cassie and Nikki who organise the MAMA Conference and who worked hard to bring together the leading lights and encourage collaboration between those of us that care so passionately about birth and the way that it works in our world.

We went from hearing about the amazing qualities of oxytocin to learning about the effects of premature clamping of the cord (thank you Dr David Hutchon and Dr Sheena Kimmond). Along the way we learned about perinatal mental health, womb ecology, labour rhythms, challenging choices, bed sharing and ended the Conference being inspired by Ina May Gaskin as she talked us through confidence and trust in birth.

## "WOWSER! WOWSER! WOWSER!!!"

There is a lot to learn and be inspired by. As the amazing Sheena Byrom said, it is so wonderful to see the collaboration of us all. And in the words of the Chair, Gillian Smith, Royal College of Midwives Director for the UK Board of Scotland, "WOWSER! WOWSER! WOWSER!!!"

The Conference attendees were midwives, student midwives, doulas, obstetricians and other birth workers. It was a predominantly female gathering but there were a few men. Set in the beautiful Troon Barcelo Hotel, the surroundings were very conducive to two days talking about oxytocin and physiological birth. Day one consisted of three main speakers and two workshops and the final day had three main speakers and one workshop.

This gave us time to listen to Ina May Gaskin as she took us through some amazing women in the history of birth, women, who like her, became midwives by less orthodox routes. Clearly something is right with the way midwifery is practised at the Farm. Their statistics are amazing:

- 1.7% ended in a Caesarean (compared to US 32.3%)
- 0.37% were forceps deliveries and 0.04% were vacuum extractions
- 3.5% were breech and of those 8.6% required a caesarean
- 1.7% had a post partum haemorrhage
- 5.4% were induced, but this was by castor oil or by stretch and sweep
- 19 sets of twins were born, all vaginally
- 1.5% epidural (compared to US 80+%)
- 99% Breastfeeding Initiation (compared to US 50%)
- 0.39% Pre-eclampsia (compared to US 7%)

Michel Odent's talk on Womb Ecology was really thought provoking. He talked about the future impact of the way that birth is managed and how the use of synthetic oxytocin and caesarean are working together to produce future generations of women who may not be able to birth their children vaginally, without assistance. He spoke of how we are the bottom of the abyss with regards to childbirth and that it was time to smash its politically correct nature and listen to common sense. An example of that was that in the past 50 years we have discovered that babies need their mothers (skin to skin and kangaroo care.)

Kirsten Uvnas Moberg talked about the two sides of oxytocin, the love hormone. We heard how it is part of mother baby bonding, free flowing milk in breastfeeding, laughter, joy and contractions in a labouring woman. The flip side of the coin is the way that trust is built and women can hand over all their wishes into the hands of health care professionals who may not have the same 'plan' for her birth.

The most moving session was about Challenging Choices where a young mother talked about the way her trust in her hospital and midwives was eroded and she decided to have unassisted births. Downe & McCourt (2008) coined the phrase 'Unique Normality'. I would encourage as many as possible to attend future MAMA Conferences.

A great quote to take from the Conference was *'I'm not a number, my babies are not just statistics and my arse is too big for pigeon holes.'*

*Mars Lord*

# Caesareans and increased risk

*Andrea Nove* reviews recent research looking at maternal outcomes following caesarean

*J.P. Souza, A.M. Gülmezoglu, P. Lumbiganon, G. Carroli, B.Fawole, P Ruyan (2010) Caesarean section without medical indications is associated with an increased risk of adverse short-term maternal outcomes: the 2004-2008 WHO Global Survey on Maternal and Perinatal Health. BMC Medicine 8(71). www.biomedcentral.com/1741-7015/8/71*

This study analysed 286,565 deliveries in medical facilities from 24 countries in Asia, Latin America and Africa. Previous studies using this dataset have found that caesarean section (CS) is associated with a higher risk of adverse maternal outcomes. This study focused particularly on caesareans for which there was no medical reason for the procedure (such as maternal request or physician recommendation without clear clinical justification). These cases made up 1% of all deliveries in the dataset (n=2,685).

**caesarean without medical indication was associated with a higher risk**

As the title of the study suggests, caesarean without medical indication was found to be associated with a significantly higher risk of negative outcomes for the mother. In comparison to spontaneous vaginal delivery at a medical facility, caesarean without medical indication was associated with a higher risk of: maternal death, admission to intensive care, blood transfusion and hysterectomy within seven days of birth. The same pattern was evident in all three continents, but the difference was particularly stark in Africa. If the caesarean was performed after labour had commenced (intrapartum caesarean), the risks were higher than if it was performed before labour commenced (antepartum caesarean). The risk of maternal death and hysterectomy was even higher for intrapartum caesarean without medical indication than for caesarean with medical indication.

The study also considered negative outcomes for the baby, and found that the risk of negative infant outcomes was significantly higher if there was an intrapartum caesarean without medical indication, but not if there was an antepartum caesarean without medical indication. In comparison to spontaneous vaginal delivery at a medical facility, intrapartum caesarean without medical indication was associated with a higher risk of perinatal death (including stillbirth and early neonatal death) and a stay of ≥7 days in intensive care. The risk of these negative infant outcomes was not significantly different if antepartum caesareans without medical indication were compared with spontaneous vaginal births.

Using statistical modelling, the study aimed to adjust for the differences between the type of woman who has a caesarean without medical indication and the type of woman who has a spontaneous vaginal delivery in a medical facility (for example birth order, birth history, age, level of education, relevant health conditions), for differences between medical facilities (such as complexity of hospital casemix) and for differences between countries. However, modelling can adjust only for the known characteristics of the mother, the medical facility and the country. There may be other, unmeasured, characteristics which partly or fully explain the difference between caesareans and vaginal births, so it would be wrong to assume that the caesarean was the sole cause of the increased risk. Nonetheless, in the absence of a randomised controlled trial (RCT) – which would be impossible (and unethical) – it is the best available way to answer the research question. It should also be noted that the method used for the survey resulted in most of the sampled countries being in the developing world, so we cannot assume that the same results would be obtained in countries such as the UK and the USA (nor indeed in developing countries that weren't included in the sample).

These results indicate that the perception of caesarean as a generally safe procedure is misguided, at least in the countries covered by this study. Whilst caesarean can undoubtedly save lives if there is a clear medical reason for the procedure, women should not be led to believe that it is necessarily as safe as vaginal birth in the absence of medical indications. The relative risks are particularly high if the decision to have a caesarean without medical indication is taken after labour has commenced.

*Andrea Nove*

## Sources of Inspiration

**'having a highly trained surgeon obstetrician assist at your birth is about as sensible as hiring a pediatric surgeon as a baby sitter for your healthy 2 year old when you go out in the evening'**

Marsden Wagner MD, published in Midwifery Today (2002), available at www.midwiferytoday.com/articles/technologyinbirth.asp

# Rosalind Jane Light

3 April 1947 ▬ 4 July 2012

Ros's death came far too early, she still had so much offer family, friends and colleagues.

Ros was diagnosed with cancer just over a year ago and following initial treatment seemed to be doing well; but sadly the cancer had spread and she declined and died shockingly quickly.

Ros was born on the 3rd April 1947 in Bradford; and although she left school after her O' Levels her self-education continued; she read avidly, and was always eager to learn more. She had a love of English History and for books, of which she had a large collection. When she retired she took a course to learn how to use her computer and Microsoft Office. She became very proficient in the use of these, much to the benefit of AIMS.

She had married her husband Alan in 1969, and they had spent most of their married life in Bewerley, a small village near Harrogate, on the edge of the Yorkshire Dales. She had a love of dogs and would get out walking them in all weather. We had often heard tales of the amount of snow that had to be dealt with where they lived.

It was her daughter Katherine's birth in1972 which brought her to AIMS. Like so many other people she was very discontented with the care she had received and sought information to make sure that she was able to get better care when John was born in 1980. She was very clear that women need to be treated with respect and dignity.

Ros was a long standing member of AIMS and in 2004 she became our Volunteer Co-ordinator. Her role was to approach every new member asking if they would be interested in volunteering and then finding them a role that they would be interested in. She also took on scanning the collection of over 170 AIMS Journals that we only had on paper, giving us an electronic collection of our Journals. Ros was also a hugely valuable member of the Journal team with her careful administration and nurturing of contributors.

When Ros took anything on, she was always so clear and careful about finding out exactly what was needed, she was then absolutely reliable in carrying out anything she said she would, and always did it so graciously and without fuss. She was so straightforward and generous in spirit and brought such a supportive view towards women and AIMS, as well as wonderful common sense to our meetings.

Ros was an excellent cook; she loved to cook both traditional and more exotic recipes. Her contributions of homemade cakes at AIMS Committee meetings were always devoured with enthusiasm. She also gardened and stored the produce of her garden in the freezer and as jams and other preserves. She loved how the seasons brought not only different weather, but different produce.

Ros was such a lovely woman, gentle, strong, very practical and passionate about her contribution to AIMS. Rather like a mother hen - she would keep us on track but make sure we were all OK. She was always finding snippets of news for us to read and kept us alert of what was going to be on Radio 4. She was always there behind the scenes but very involved with what we were doing. We are all going to miss her enormously.

*Debbie Chippington Derrick*

Ros with other Committee Members trying out the AIMS T-shirts at a committee meeting in Oxford.

Back row:
Jean Robinson,
Glenys Rowlands,
Gill Boden,
Shane Ridley,
Nadine Edwards, Ros and Gina Lowdon
Front row:
Michelle Barnes and Beverley Beech

# A story of three births

*Chloe Bayfield* shares the story of her journey to empowered motherhood

So I have had three gorgeous baby girls by caesarean, despite following an almost identical path of "high risks" each pregnancy was in no way similar to the others. I got a little older along the way, more active and my diet improved a little, but I did not change enough to warrant such a difference, especially given the omnipresence of said risks.

With all three of my babies I had a combination of a long list of "high risks" including: high blood pressure, suspected gestational diabetes, breech baby, large baby small mummy, oedema, polyhydramnios and long pregnancies (up to 43 weeks). How is it possible that these things have resulted in my having a long protracted hospital stay, medication and a battery of tests followed by an automatic caesarean in one pregnancy? Whilst another such scenario was surrounded by little to no tests and a long natural labour at home?

Such has been my childbirth journey, I had to stop at A in order to get to C, and I have to make my peace with that because it has brought about a lot of positive changes in my life. What scares me to death is the future of other pregnant, hormonal and vulnerable mothers. Should they not be made aware that whilst they are well within their rights to choose path A with all its long term ramifications, there are other options....

My first two pregnancies were two years apart at different hospitals, though only ten miles apart. The first at Southmead, one of the county's leading maternity units and the second at St Michaels. My first pregnancy flagged all of the above risks, apart from the breech complication, though probably because I only got to 38 weeks. I therefore spent much more time in hospital or seeing consultants than I did my midwife.

I spent the entire pregnancy being scared, told my baby was huge, my blood pressure was soaring, my frame was tiny, my sugar levels would surely be having a detrimental effect on my baby (at no point did they look at my diet). It was my first baby and I was petrified anyway, when they said take medication to help with the blood pressure I fell on it gratefully. When they said have a casaerean I bit their hands off. They explained that the chances of me birthing my baby were very slim, that even if I did I would rip and tear, adding that I would have stitches somewhere why not choose to have them on my stomach, much more comfortable! Cut to a ten day hospital stay in a room with no window, postnatal depression and a short stint of breastfeeding.

Pregnancy number two was very different. My booking midwife was happy with my plan to birth naturally this time (I had no idea how rare this is at the time) and didn't seem fazed by my previous pregnancy complications. I asked for a natural birth without having done any research, it was born only from my overwhelming desire to never have another caesarean.

This time round when my blood pressure went up I went into the day assessment unit but was home within a few hours. When I enquired about medication they informed me that they didn't give it as they didn't feel it was safe. After the first glucose tolerance test I refused the second and improved my diet. They weren't worried about my baby looking large on the numerous scans and didn't bat an eyelid when my pregnancy approached the 43 week mark. I think I saw one consultant throughout the pregnancy.

Then my little girl turned breech and it was game over, into the operating theatre two days later. Cut to a very very long recovery process with an even shorter breastfeeding stint and post natal depression. I had recurring mastitis and scar infections, a tooth abscess, bronchitis and sinusitis within the first month.

It took me eight years to feel ready for the next baby. Having watched my other two grow I decided that it was worth going through all of the above again to have another. My booking midwife was the same lady I had with my first baby. She told me that there was no way I would be allowed a VBAC attempt, she scheduled in my glucose tolerance tests and an appointment to book the caesarean. I got to about 20 weeks and then my wonderful sister in law gave me her AIMS Am I Allowed and VBAC books. Even writing this I can feel the weight of the other two births lift, this was the turning point. Just two little books.

I rushed back to my midwife, I was so excited, I told her what I had found out and explained my plans to have a home birth. She didn't share my excitement, luckily I knew this may happen and had taken my husband. She told me how the chances were both baby and I would die, she cited times when she had witnessed such a thing. Even with the little reading I had done at that point I could see the flaw in her argument, but that's another story. My husband was my hero that day, after every scare story he said 'We understand, but this is our choice, please can you write it in the notes' whilst I quietly cried. I then tentatively mentioned my research into independent midwives. My NHS midwife explained that an independent midwife would tell you she would help with any birthing scenario as she wanted your money. She went onto relate a story of an independent midwife trying to revive a still born baby with homeopathic remedies.

Enter the wonderful independent midwife. A very experienced lady who has been a midwife since before I was born. Whenever I mention her name to anybody within the birthing world I hear another positive story. We met and I instantly felt I could trust her, she looked at my history carefully and felt I could achieve my goal.

There was also an acknowledgement of the potential risks, which I was very happy with; I didn't just want to pay to hear what I wanted. Finally, somebody who knew what they were doing and supported my choices. All the worry fell away and I could finally just enjoy being pregnant.

I am at my happiest when I'm pregnant, I am content and at peace. Unlike my normal state of impatience, worry and frustration! I even love the last part when you are so huge you feel like you might fall over, and I do tend to get fairly big. This time round I wasn't poorly, I wasn't a patient, I was pregnant. My appointments were held at my midwife's home and I grew to love it there, it was like a safe little cocoon. I looked forward to them instead of dreading them. I can honestly say that my third pregnancy was one of the happiest most peaceful periods of my life.

My blood pressure went up a bit, but we (WE!) watched for other signs of anything being awry and, as there weren't any, let things be. It was also acknowledged, for the first time, that my blood pressure had been fairly high on booking, meaning that the rise itself wasn't huge. Same with my sugar levels, large baby, going post-dates, all fell within the normal remit of my pregnancy. Instead of automatically ticking some box somewhere and then trundling off down the road marked intervention, my midwife acknowledged that this was how pregnancies ran for me. Not to say for a moment that she wasn't watching for anything worrying, it was just done without worrying me unnecessarily. I respected her experience and trusted her, whilst she respected the natural process of growing a baby.

## variation of a natural birth and certainly something I could handle

Baby number three did also turn breech at around 41 weeks, but instead of the world falling around my ears we altered my birth plan accordingly. Having read a fair amount of Mary Cronk's work, and discussed it with my midwife, I was happy that this was just a variation of a natural birth and certainly something I could handle. My little girl did turn head down again at about 42 weeks though.

Then came the labour, something I had never done before. The anticipation of 'will today be the day' was amazing, for the first time I was ready to give birth. As I said, I love being pregnant and don't usually want the pregnancies to end, but going into labour naturally meant that for the first time I got to a point where I did want baby to come. I got grumpy, restless and impatient and I love that I did! The weekend I spent labouring at home with my husband was one of the most amazing weekends we have ever experienced.

We watched TV; I got in and out of the bath and the pool, my midwife popped in to check me periodically. We were in a little bubble all of our own, sharing the most amazing experience. I know my midwife came, and I was reassured by her intermittent presence and phone calls, but she wasn't really in the bubble, if that makes sense... Which is exactly how I wanted it, it was just my husband and I, though with some wonderful support there, ready if we needed it.

Unfortunately after a long labour my little girl didn't want to be born naturally and we did end up with another caesarean. But that is OK. I went into that operation on a high, I had achieved something amazing, and for the first time in any pregnancy I felt euphoric. My baby had chosen her own birthday, we had both experienced labour and all its benefits, I was ecstatic.

Cut to a very short and uneventful recovery followed by a long stint of breastfeeding. Notice the complete absence of postnatal depression and observe the palpable bond between mother and baby.

How can three almost identical pregnancies be so entirely different? How is it OK that two left me doubting myself, my mothering skills and my life choices whilst one enriched every aspect of my life? How do we address the balance and protect future mothers from unnecessary pain?

*Chloe Bayfield*

## Quotation Corner

Midwife (loudly) to woman in birth pool – baby crowning:

**'reach down between your legs and find my hand, I'll guide you to your baby's head.'**

Midwife, at a conference:

**'Women can't check their own cervix, how would they know what it feels like normally...'**

Midwife, justifying refusing a woman use of the birth pool:

**'You have high blood pressure, so you are high-risk. Water can reduce it so we can't let you in the pool in case it drops. Lets get you in the bath instead.'**

# Twins and lack of consent

*Kate Cox* describes her experience birthing premature twins

I arrived at the Delivery Suite at 32+3 weeks gestation having regular contractions. I was scanned on arrival as both babies had seemed transverse for most of the pregnancy. The consultant could see that twin one was now oblique breech and twin two complete breech, so recommended I start to prepare for an elective caesarean section birth. I was not happy to do so at this point, since despite the myth that there is not enough room, twins are notorious for turning even during labour. I had four children at home to look after, as well as the impending stress of caring for preemies in hospital, which I knew would require the best physical condition I could achieve and I also did not want major surgery just because I did not want major surgery! I wanted the best outcome for all of us.

I had read about breech birth and devoured everything I could on outcomes and best positions, so I upped myself onto all fours and swayed my hips, speaking to my babies, praying and gently swinging. Eventually we had a VE which showed I was 4-5cms and the energy of the staff increased a little, with more talk about surgery. Not long after I asked for another VE as I felt that I was very close to birth and I wanted to know the position of twin one at this point. The midwife could feel a scrotum, so I felt reassured that baby was sufficiently well positioned to continue as we were. The registrar appeared and I asked when we'd know for sure if it was safe to birth vaginally. He said, 'when baby comes out or not.' At which point I felt my body relax and twin one came out in his sack.

**I still can't see evidence for why all this was necessary**

Sadly, his cord was immediately cut and he was taken away from me; no chance to see his face, stroke his skin or smell him before they essentially stole him away to SCBU and banned both my husband and other birth partner from accompanying him. I still can't see evidence for why all this was necessary and he later had to be ventilated, which I am sure is linked to the rude awakening from his cosy womb.

The commotion then increased for me to turn over so they could scan and check twin two, but the waves of contractions had mercifully started up again and she made an appearance just four minutes later, in all her breech glory. I felt her body born, legs unfolding, a pause, then the head released.

Again, she was immediately taken away from me but briefly returned once they had given her inflation breaths. She was by far the weaker twin, but never needed ventilation. A Mother's touch, smell, sound makes a humble but profound difference. I can not help but wonder if either twin would have needed inflation breaths if their cords had been left and they had been offered a more gentle transition.

I know my case is not a full term story, but it is a breech story of a minor victory in a sea of disempowerment that made everything afterwards more endurable. It also made me realise the vulnerability of parental choice over medical advice, even when there is research to back up our parental choice. One might wonder when evidence based practice will truly be implemented, rather than the following of comfortable protocol that treats everyone as a worst case scenario, regardless of the collateral damage caused along the way.

We all want live babies, but birth choice is not simply about this outcome. There is so much more to birth than life or death.

*Kate Cox*

## The problems of birth at home

One of the frequent appeals for help on our helpline is from women who want to birth at home but find innumerable obstacles put in their way. Despite the evidence to the contrary, health professionals often tell women that home birth is dangerous, or that the research is inadequate and, therefore, the staff cannot support the woman's intentions. The implication is that hospital is safe, yet a target of 100% hospital delivery is the biggest unevaluated medical experiment in the world.

Since the drive to ensure that every woman births in hospital the home birth rate has declined. In recent years there has been a recognition that home birth is safe for many women but the home birth rate nationally has only increased to less than 3%, and in many areas it has yet to reach 2%.

Were Trusts to fully support a quality home birth service they could save a fortune, not only in the reduction in caesarean sections, but also in their drugs bill and both women and babies would be healthier and less traumatised by their experiences. Breastfeeding rates would improve enormously.

In response to the lack of information women have about home birth AIMS has published a briefing paper which addresses all these issues (and quite a few more) and can be accessed at www.aims.org.uk/OccasionalPapers/benefitsOfHomebirth.pdf

# Reviews

## *Rebounding From Childbirth: Toward Emotional Recovery*

*By Lynn Madsen*
*Bergin and Garvey*
*ISBN-13: 978-0897893480*

I found this book so emotionally empowering that I wanted to shout about the capacity it has for helping to heal. The only way to explain this is to review it in relation to how it has helped me.

Madsen begins in the best way possible for showing empathy and understanding for trauma in birth, by telling her own story. As someone who experienced a necessary and life saving emergency caesarean section and then a healing vaginal birth, as a reader you know instantly that she understands the full range of emotions that can come with childbirth. The extent of this I feel is clearly portrayed in the following excerpt from her birth story.

*'"I'm very sorry your expectations didn't get met", Expectations! Beyond expectations, I landed on another planet. I am only grateful to be alive because Evan is alive. I know the future holds this child who was born precipitously and that is good. But the present is horrible. The present still holds tubes and catheters, difficulties walking across the room, an inability to care for my own baby. The midwife asks if I've cried at all. I say I haven't because it hurts too much. She thinks I mean too emotionally painful. I mean too physically painful. I want to cry, but my belly screams out with any sob, so I smother them. Too much pain. Don't touch my stomach!'*

*p.xix*

**For me it started to unlock the flood gates**

To some, this may seem an extreme response. For me it started to unlock the flood gates. On reading her birth stories and hearing her own pain, I allowed myself to remember the pain, physical and emotional.

Not only is Madsen a mother who has had a VBAC but she is also a psychotherapist. On experiencing her own birth traumas she sought out literature to explain, and support her healing process, only to find that there was none. So she wrote this book.

The book is set out, after the birth stories, into separate chapters dealing with separate elements of childbirth and early motherhood, how it can affect you and how you can begin to heal. Two other women's birth stories are shared also, in order to give a comparative account of how different experiences can be traumatic in different ways, but follow similar patterns and need the same amount of attention. Each chapter ends with a few reflective questions and these questions are aimed at starting your own process of awareness of your own trauma, and subsequently how to process it.

**she shows how her own and the other women's' stories showed many of the symptoms that would result in a diagnosis of PTSD**

Madsen begins by describing definitions and symptoms of Post Traumatic Stress Disorder (PTSD). In doing this she shows how her own and the other women's' stories showed many of the symptoms that would result in a diagnosis of PTSD for each of them. For me I found this chapter illuminating. She described how recognising that an experience has had elements of trauma, and recognising that we have had specific responses to that trauma is the first part of healing. I instantly thought, 'oh well this part does not relate to my experience, it was not traumatic enough'. Then I began to read some of the symptoms, and some of them just jumped out at me! I will not list them all, only the ones I have realised describe my 'responses' exactly.

Recurrent and intrusive distressing recollections of the event – I still have this almost three years on. My Sister in Law gave birth yesterday and my thoughts before bed went straight back to the build up to my own EMCS, even though I have had a wonderful VBAC since.

Intense psychological distress at exposure to events that symbolise or resemble an aspect of the traumatic event including anniversaries – I know of many women who experience extreme distress on the anniversaries of their traumatic birth experiences, on their children's birthdays. For me, I have not noticed any response to the anniversary but I have had some startlingly strong responses to other exposure. Reading or hearing birth stories of first time mothers who have positive experiences, watching caesarean sections on the TV and if I am being totally honest, writing the word caesarean. For a long time I have used the phrase 'section' as I found this easier to tolerate than the word caesarean. Looking clearly at it now it is definitely a response to my own experience.

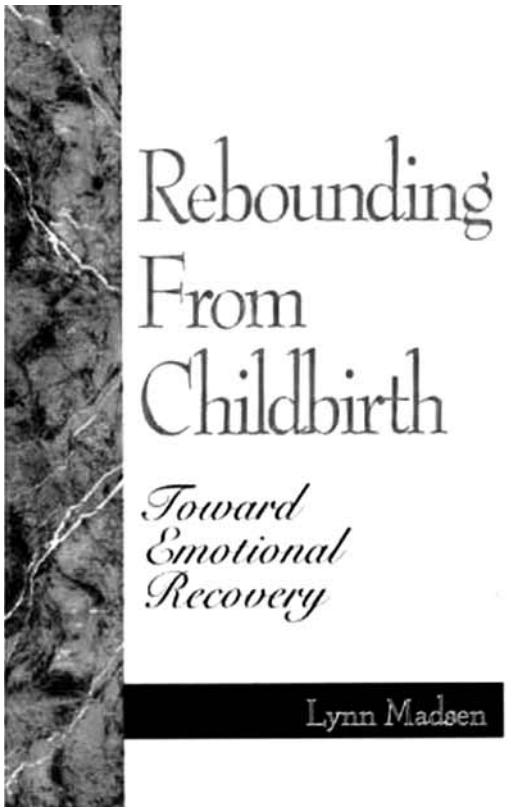
Efforts to avoid thoughts or feelings associated with the Trauma – Not only did I try to avoid listening to other people's birth stories as I felt I could not really join in or be 'part of the club' but I also initially got very angry at people who showed pity to me. I did not want to acknowledge my disappointment at all.

Madsen explains that healing requires acknowledging these responses, and paying attention to them can help 'clear the trauma'. Using some of the reflective questions at the back of the chapters I decided to look back at the birth stories I had written about my EMCS and then subsequent VBAC. The positive VBAC was a lovely long story covering everything. The EMCS story was surprisingly to me very brief. I had skipped over massive areas, not recollected everything and actually made it sound much more positive than it was. I was so determined to prove that I had handled it that I was actually hiding many elements of it. I had not written about being left on my own after being induced to cope with my first painful labour alone and terrified. I had not written about the agony of trying to stay still while heavily contracting, whilst they gave me an epidural that I had not even wanted. As Madsen describes I had 'minimised' my whole experience. In my mind I believed I had done this for myself, to remember the positive elements, as I do tend to do this in life. What I was actually doing, as Madsen explains was suppressing my true responses, causing a delayed onset – which can occur over six months later. Mine actually did not occur truly until I read this book, several months after my VBAC over two years after the birth.

I rewrote my EMCS story, still struggling to truly put down all my feelings about it, but at least putting in all the elements that WERE traumatic for me. This book, and the process that it has started in me has led me to many tears, but it provides some understanding about how important it is to recognise and acknowledge birth trauma and other traumas related to pregnancy and motherhood. This book gives a huge insight not only into how to recognise and acknowledge the traumas associated with this time of life, but also the importance of recognising and acknowledging the responses to the traumas.

**a way of writing that truly makes you think about your own experience and reflect**

Madsen has a way of writing that truly makes you think about your own experience and reflect. The questions that she asks at the end of the chapter draw things out that you had not even thought of before. She talks of the 'but you have a healthy baby' phrase that many of us know and hate so well. She gives voice to the frustrations that can be felt when partners do not




understand or are facing their own traumas regarding the birth. She covers trust, family history and how that can affect your own birth – which has elements of Ina May Gaskin's ideas of holding on to fears/anxieties or major life events that can affect your labour and birth.

Another area covered is Post Natal Depression and again how we are inclined to 'minimise' our own experiences and not fully acknowledge how we feel about our own experience. Comparing our own stories with others is something we do constantly and she suggests this is not always helpful as it is another form of minimising our own experience and not allowing us to pay attention to ourselves and our own feelings.

What this book does, that I found really powerful, is encourage us to ask more questions. Questions of ourselves. In questioning ourselves honestly we are able to start to find the roots, or at least some of the roots of our responses and how to heal with them.

I would recommend this book to anyone who is or works with those who are traumatised by a birth, anyone who feels that they are struggling to come to terms with a birth, and also to those like me who don't acknowledge they are struggling but who have many what ifs or questions about the birth. In fact, anyone who has given birth and experienced the dramatic life change that motherhood brings should read this book!

*'A woman calls out, speaks out, and moves forward. The trauma is defined, the power of denial diminishes'*

*p.90*

*Susan Merrick*

# Letters

## Well-timed

I have just started to read the journal and wanted to say congratulations to all on what looks to be a brilliant issue.

It is well timed in the light of the recent terrible news about what has been going on at Barking, Havering and Redbridge – another huge unit formed by mergers – now reducing its number of births from 10,000 to 9,000...

Here's the link to the Independent article but I'm sure you will have seen the news www.independent.co.uk/life-style/health-and-families/health-news/inspectors-find-culture-of-abuse-in-nhs-trusts-maternity-services-2376931.html

*Sarah*

## Birth Norms

Since the births of my children I have become more and more involved and passionate about women's rights, access, choice, information and status in maternity.

I am especially interested in the areas of access to information and how this information is given within maternity services as I feel this has a huge impact on women's belief in themselves and birth as well as the choices they make. I feel very strongly about the anecdotal evidence that suggests that women really are not aware of their choices or not confident in exercising their choice in maternity care. I am a member of my local MSUG and MSLC (which is shared between three hospitals.)

I'm really excited to have joined AIMS, I love the journal and feel privileged to be in the virtual presence of such a wealth of experience and knowledge within this organisation.

After reading the NHS commissioning article (www.commissioningboard.nhs.uk/files/2012/07/comm-maternity-services.pdf) the few elements that jumped out at me were:

- They discuss future costs of 9million for 4000 women which comes out at £2250 (compared to £2800 currently) Is that right? Are they expecting costs to go down ....?
- The article still talks about 'allocating' women pathways ... Rather than providing various pathways for women to choose from and ensuring women can opt in and out of the pathways offered also.
- Pregnancy is to be promoted as a normal physiological process, yet they want to put in place intricate care plans, risk assessments etc. It does not send the message that it is a normal process.
- The focus on choice and woman centred care is good, as long as it truly is.
- The focus on midwifery led care based on the Birthplace Study (summary and further information is available at www.npeu.ox.ac.uk/birthplace) is great, hopefully we can see some birth centres reopening and their services being advertised more openly!

There are so many elements within hospital birth that make me cross or just seem ridiculous that I have supported the parents in avoiding/working with/declining that I would never choose to birth a baby in hospital myself again.

It makes me tempted to only work with women who want a home birth, but I guess it may be the women who 'choose' hospital who need more support...

I realise even more how ridiculous it is for birth in hospital to be the norm.

*Susan Merrick*
*VBAC mum, Doula and BSL Interpreter*

## Well-timed

I would like to express my extreme sadness at two previous issues of the AIMS Journal, Journals Vol. 23 No. 4 and Vol. 24 No. 1.

Not because the content is sad, but because if I had read these Journals three years ago I could have spared myself a great deal of birth trauma.

I am desperately saddened to find that my midwives and doctors did not know the information so clearly presented by the authors on the real risks of carrying excess body weight. Being 'pregnant and fat' I was clearly not as 'high-risk' as I was led to believe. I am a tall woman, I have a high BMI, but I am fit, healthy and well nourished. I exercise, I do not have gestational diabetes, although you'd think the number of times I was persuaded to test for it, and the amount of fuss that was made over it, that it was a known fact that I did! I gained little weight during my pregnancy (in fact when my baby was born I was lighter than before.) My baby was of a good weight for my frame, after all, you would not expect a woman of 5'10", with baby's father standing 6'2" to have a 7lb baby, if I'd had a baby that size I would have been sure he was underweight at birth due to my early pregnancy sickness.

Still, I was persuaded to go for induction of my big (8lb 10oz) baby, which led to emergency surgery and a long recovery. If my care team had known what is clearly available and had not bullied me into thinking that my 'big' baby would die during birth if I carried on letting him grow I could have had a very different birth. Next time I will know better. Thank you AIMS for talking such common sense.

*Lara P*

## JOURNALS & BOOKS

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

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

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

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

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

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

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

Choosing a Waterbirth by Beverley Beech: How to arrange a water birth, pool rental, hospitals with pools; help to overcome any obstacles encountered. £5.00

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

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

Induction: Do I Really Need It? by Sara Wickham: An in-depth look into the options for women whose babies are 'overdue', as well as those who may or may not have gestational diabetes, or whose waters have broken but have not gone into labour. £5.00

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

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

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

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

What's Right for Me? by Sara Wickham: Making the right choice of maternity care. £5.00

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

## MISCELLANEOUS

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

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

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

What is AIMS?: Activities of AIMS, the campaigns it has fought and its current campaigns FREE

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

- Am I Allowed?
- Birth after Caesarean
- Birthing Your Baby: Second Stage
- Birthing Your Placenta: The Third Stage
- Breech Birth: What Are My Options?
- Induction: Do I Really Need It?
- Making a Complaint about Maternity Care
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- What's Right for Me?

First-Time Mothers' 7 Book Bundle £30.00
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# Noticeboard

## AIMS Meetings

Friday 14 September 2012, London
Saturday 20 October 2012,York
Friday 30 November 2012, Oxford

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

## AIMS Event

Working with Pain in Labour – Interactive talk with Nicky Leap
Thursday 27 September 2012
19:00 – 21:30
Bristol Aquarium
Light refreshments provided
£15.00 (£10 for AIMS Members)
Contact Chloe Bayfield
email chloe.bayfield@aims.org.uk
www.aims.org.uk?NickyLeapTalk.htm

## The Dorset Home Birth Group
## Home Birth Matters

Saturday 13 October 2012
Bournemouth

Key Speakers
Professor Paul Lewis, Emeritus Professor, Bournemouth University
Clara Haken, Consultant Midwife for Normal Birth, Kingston Hospital NHS Trust

£30 Registered Midwives and other professionals
£25 for Students and unwaged

Enquiries to Claire Williams
dorsethomebirthgroup@googlemail.com
07795 002227

## Stroud Maternity Matters
## Stand up for Birth –

Normality, home birth, birth choices for high-risk pregnancies

Saturday 1 December 2012
Stroud

Key Speakers
Denis Walsh, Sally Randall, Sue Dennett

£30 Professionals and lay workers
£25 for Students and unwaged
Includes lunch and tea.

Money raised goes towards supporting women and families via Stroud Maternity Matters.

Enquiries
mandyrb@tiscali.co.uk

*AIMS would like to thank you for your support over the last 50 years of campaigning for improvement to the maternity services*

## MEMBERSHIP FORM

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If new member, how did you hear about AIMS? .....

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❑ I would like to join AIMS ❑ Please send me a Standing Order form ❑ Please renew my membership

Please enclose a cheque/postal order made payable to AIMS for:

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Please note that personal subscription is restricted to payments made from personal funds for delivery to a private address

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