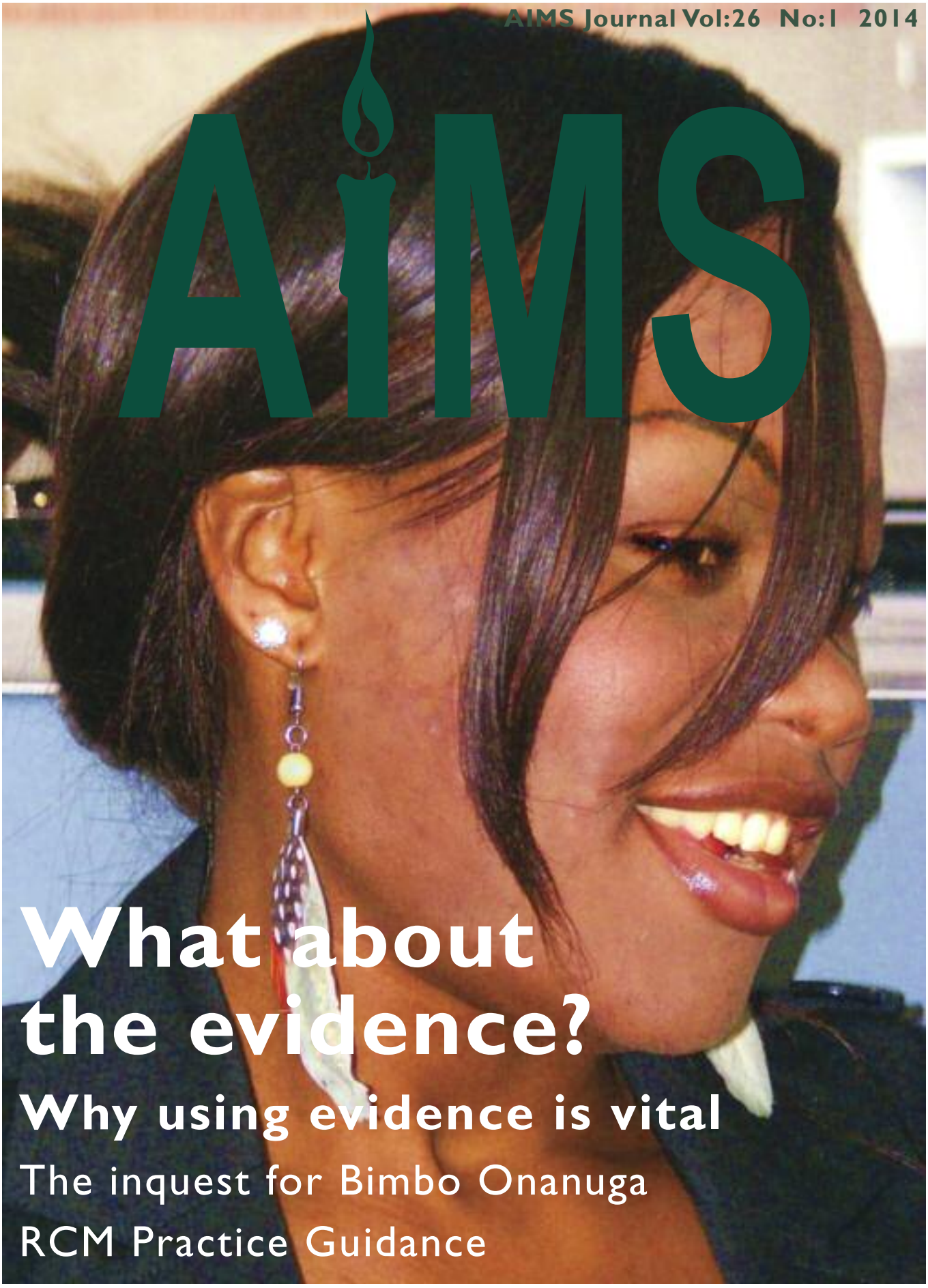
Association for Improvements in the Maternity Services

AIMS Journal Vol:26 No:1 2014

# AIMS



# What about the evidence?

## Why using evidence is vital

The inquest for Bimbo Onanuga

RCM Practice Guidance

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# Diary

**AIMS AGM**
Saturday 5 July 2014
at F.A.B
Families and babies one stop shop
Westmorland House
Brook Street
WAKEFIELD
WF1 1QW
10am – 4pm

Speaker: Becky Reed, Midwife, Albany Midwifery Practice

**Members please come and join us for our annual meeting**
**Bring and share lunch**

RSVP secretary@aims.org.uk

## AIMS Meetings

Friday 4 July 2014 – Selby
Thursday 18 September 2014 – London
Friday 28 November 2014 – Bristol

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

## AIMS Talks

For details of forthcoming talks please visit www.aims.org.uk

## Breastfeeding Festival

2 & 3 August 2014
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University of Manchester Students' Union

£3 per day, payable on the door

Further details at breastfeedingfestival.com

North of England Breech Conference

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Chaired by: Sheena Byrom OBE & Mr Laurence Impey FRCOG

- The evidence and physiology of vaginal breech birth
- Upright vs supine breech birth
- Developing a robust breech pathway
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Suitable for midwives, obstetricians, educators, students

Register at www.sheffieldconferences.org
Full Price: £160
Early Bird: £120

Association for Improvements in the Maternity Services
founded in 1960
by
Sally Willington 1931 – 2008

# AIMS

campaigning for better maternity services for over 50 years

# AIMS



## Hon President
## Jean Robinson

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

Vol:26 No:1
ISSN 0265 5004

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Printed by
**QP Printing, London**
Tel: 020 3332 0102



Cover Picture:
Bimbo Onanuga, who died 4 March 2010. © Abiola Adesina.

# Contents

# Reporting drug reactions

**The Medicines and Healthcare Products Regulatory Agency (MHRA) has updated its online Yellow Card reporting form for reporting suspected adverse reactions to medicines.**

This system allows clinicians and members of the public to report any adverse effects of medicines or drugs.

Women often take medicines while pregnant or before they know they are pregnant. However, there is commonly little information available on a medicine's effect on human pregnancy before it is licensed. Therefore it is important to collect reports of suspected adverse reactions experienced by a woman or child associated with medicines taken during pregnancy, labour, postnatally and for adverse reactions experienced by a baby.

This information improves the understanding of a drug's effect during pregnancy and informs treatment decisions to maximise the benefit and minimise the risk to both woman and child.

A copy of the form can be downloaded and sent to the MHRA via freepost: yellowcard.mhra.gov.uk/_assets/files/HCP-Yellow-Card-07-2013-vFinal.pdf

# Ágnes Geréb, finally free from house arrest

Story on page 27

Ágnes attending the Budapest Homebirth Children's Meeting, 5 April 2014

© Donal Kerry
Justice Campaign for Ágnes Geréb

# What else is in that?

**AIMS is often asked about the content of drugs by those with allergies or who practise abstinence diets (for example, vegetarians), for religious food observances and by those who want to know what they are taking into their bodies.**

Unlike laws for food labelling in the UK, there is no similar requirement for medicine. Drug information sheets are included with all medicines and we recommend that you read them carefully before taking the drug and tell the doctor any information that may be relevant.

However, it is likely that you will only be shown this information sheet by hospital staff if you ask to see it. Medicines are only required to give details of 'active ingredients' they contain, which must be listed on the drug information sheet. Medicines will also have 'inactive ingredients', which are components of the drug that generally do not increase or affect the therapeutic action of the active ingredient. Inactive ingredients are used to make the tablets or solutions that contain the drugs and to make those that need to be swallowed palatable (such as coating of tablets). Examples include binding agents, dyes, preservatives and flavouring. It is possible that these inactive ingredients may cause allergic or adverse reactions.

It is extremely difficult to find out whether any medicines have active or inactive ingredients that are made from animal products or other ingredients that may be unacceptable to some people. If you are told a drug is synthetic, it may still be animal derived.

Chemical synthesis is often very complicated and using an animal source may make the production easier and hence cheaper, or there may be no suitable chemicals to use in the production process that can be obtained from plants. If a drug has been manufactured abroad, such as in China, details of the source may not be available.

The advice given to AIMS by a drugs company is to phone them direct to find out what was used to make each individual drug you wish to know about. You would need to do so for each different batch of drugs, because the ingredients could vary between batches of the same drug, although the quantity of the active ingredient would stay the same.

Please note that medical staff and midwives are unlikely to know whether the drug contains 'ingredients' that you wish to avoid or not. The information is not on the patient information sheet (there are no requirements for it to be) and neither is it in the British National Formulary (the book and website they use to obtain information about drug constituents – see www.bnf.org). Ask for written information if staff claim knowledge.

It may be worth speaking to a pharmacist, either your local one or the hospital pharmacist, as they are likely to know more about the drug – although their sources of information are likely to be the same. Again, check their knowledge and ask for written information.

Be aware, also, that you may be obtaining information about a drug with a certain brand name, however, the NHS may prescribe you another, cheaper version containing the same drug, but with different inactive ingredients. If so, you will have to start your checks all over again.

There are three useful websites where you may find information – an American one www.drugs.com and two UK ones www.medicines.org.uk and www.mhra.gov.uk/#page=DynamicListMedicines.

# Woman-led care

*Vicki Williams* asks for evidence and compassion in maternity services

**Women remember the births of their children forever. I am not alone in thinking that it is deeply important to consider it a priority to ensure that any support offered carries positive memories of care, compassion and quality.**

Recently I had the honour of listening to a group of very elderly ladies from a local nursing home, aged (they were proud to tell me) between 84 and 102, cooing over the great-grandchild of one of the group. Having just walked from supporting an antenatal group into their fundraising cake sale in the same building, I was enveloped as a willing admirer of a beautiful baby boy and his beaming mum. Quickly the conversation turned to the births of their own children. The stories were similar to ones I hear in mums' groups regularly, the good stories, the funny stories, the heart-warming and heart-wrenching, but what struck me was the absolute clarity with which this group of women remembered their birth experiences 50 to 80 years ago. A clarity which at least one of the group didn't show when trying to recount what she had done that morning! They remembered the look, feel, smell of their babies, every last detail sharp. They also remembered those who cared for them, and the way those carers and the care they gave made them feel. The raw emotions were still there, little tempered by a lifetime of experiences that followed.

As life events go, birth is a big one. Good or bad, memories and emotions of pregnancy and birth are etched into a woman's mind and body and help shape the psyche of her child.[1]

If a woman is going to remember her birth that clearly, it is essential it has a positive impact, even if events do not go as she hoped. Regardless of intervention or disturbance in the birth space, everyone present must ensure that whatever happens is for the benefit of mum and baby rather than the convenience of the system or because a guideline has become a rule, because the woman will most likely remember her care forever.

It seems far too common for women to have negative experiences of childbirth. A recent study by BirthRights[2] makes for depressing reading. Amongst the 63% of women who reported that birth affected their feelings, a staggering 41% of them said that the impact on their self image was negative. Of those who reported an effect on the relationship with their baby, 22% (38% for first-time mums) said it was negative. Unsurprisingly, hospital and intervention-heavy births had much worse outcomes than births in midwife-led units or at home. It seems likely that this study is an accurate reflection, as similar results were found in Scotland.[3]

The effect of a system where process and power has become more important than the woman is highlighted clearly in Jo Murphy-Lawless's account of the inquests into maternal deaths in Ireland on page 6. Women deserve better; professional guidance needs to be robust, truly evidence based and, above all, flexible, so it can be incorporated into individualised care plans where a woman's decisions are central. Tick-box care and lists of actions to take regardless of individual needs can be dangerous.

There seems to be a tendency for medical care not only to display action bias,[4] but also to struggle with informed consent, often only giving the information that will lead a woman to agree. Glossing over, or even omitting, the information or evidence that does not support the intervention being proposed is common, as are health practitioners who constantly repeat their advice or predictions of doom until a woman agrees.

Guidance for midwives often reflects and incorporates good practice, but then is in conflict with protocols and accepted practice, leaving midwives floundering between giving good, responsive and evidence-based care and working in a situation where they are over-stretched and where tick-box care allows several midwives to share the care of many women. On page 11 Susan Merrick shares her thoughts on guidance for midwives. On page 13 Jo Dagustun looks at the use of water in birth.

In an age when most of the UK population has access to the internet, women now not only have the desire to seek information about their options, decisions and care, they have access to the same wealth of information that was previously the preserve of academics, medical professionals and the seriously determined. A useful summary tool is the information collected by BirthChoiceUK, in conjunction with Which?, and presented as an accessible guide to birth statistics to help women make decisions about where to have their baby (see page 15).

So, if birth has such an impact, how can the 'at least you have a healthy baby' line come even close to helping a woman to process negative experiences? If a woman feels disempowered, ignored or abused by the process, it is likely that she will take those memories, with a great deal of clarity, to her grave. Of course she is happy to have a healthy baby, but traumatising a mother in the process can affect her, her baby, her partner, her other children and her wider family. Her experience matters and it is in everyone's interests to put these issues at the forefront of any agenda. Presentations such as the Health Education England meetings, reported on page 16, suggest there is a real place for campaigns to make a big change in an already rapidly changing system where care is becoming increasingly fragmented.

The AIMS journey began more than 50 years ago, summed up in The Face of Birth (page 18) by their quote *'a "willing woman" who wants to give birth with minimal intervention is now considered counter culture.'* Join us in working towards a culture where the will of the woman is the most important factor in decision making: more than woman-centred care, it should be woman-led.

*Vicki Williams*

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# A brief glimpse into hell

*Jo Murphy-Lawless* looks at what lies behind the Irish inquest into Bimbo Onanuga's death

**In a corridor of the Rotunda Maternity Hospital a man falls to his knees, shaking with tears, his voice hoarse from screaming for help. His dear wife has collapsed in the room behind him. No staff member, not midwife, nurse, or doctor, nor any other person reaches down to comfort him.**

His name is Abiola Adesina. His wife, who has experienced an intrauterine fetal death, is herself dying. Her name is Bimbo Onanuga. She will leave behind her a daughter, Nelly, who is seven, and who sustained devastating injuries at birth in Limerick Regional Hospital resulting in severe cerebral palsy. Bimbo has been the devoted carer of this beloved daughter since her birth.

### Why understanding background circumstances matters

The AIMS membership, its hardworking committee, and all those who come to read the AIMS Journal care deeply about best conditions of practice to secure best birthing for women. We know that the care of each pregnant woman should reflect precisely her needs in all their dimensions. Rosemary Mander and I have recently stated the necessity of understanding the politics of maternity at fundamental levels, peeling back the concrete problems we see on a daily basis in our dysfunctional maternity services, to explore the power issues that are at the root of how contemporary governments and state-sanctioned institutions 'see' those same services. We have argued that it is imperative to understand fully what they value and what they choose to override.[1]

Within the British context, and certainly within the rapidly privatising NHS in England in the wake of the Health and Social Care Act,[2] this entails identifying how these inaccessible institutions spin their webs of influence on, create their definitions of, and distribute funding for maternity care. This level of analysis helps us to make sense of the chicanery that lies behind such moves as the 'reconfiguration' of maternal services in the Greater Manchester area that actually deprived vulnerable women of vital support.[3] We can see that after decades of the stated intent by British neoliberals to do so and the resulting starvation of funds for frontline services amidst a nightmare of managerial overload, the NHS now faces the risk of being broken up, taking with it the finest examples of maternity care across the country for which women, midwives and communities have fought so long.[4]

### Ireland and its cataclysms

It is harder to track the structural cataclysm of the Irish maternity system because the connections between it and the political ideology that sustains it are nowhere near clear-cut. In Ireland, maternity care has been available free of charge for all women since 1991. Yet the reasons for poor maternity services and the continuing reliance on an obstetric-consultant-driven system of care, where extensive private practice is intermingled with public provision provided by the same obstetricians, are far less apparent to the general public and far more hidden to the individual woman who becomes pregnant and who needs care.

Sociologists like myself might regularly draw attention to the 'patriarchal dividend' that characterises Irish society, where too few questions are asked about the ease with which men dominate and benefit from our existing institutions.[5] People who are meant to be policymakers just as regularly speak about the need for 'transparency' and 'accountability' of these same institutions where male-dominant power makes itself felt, and leave it at that, neither expecting nor getting any more than the exchange of fine words.

**the unspeakable truth known to all who work with and in these services**

In the wake of Savita Halappanavar's death in 2012, her inquest was followed by a series of reports of which the final one to be issued by the Health Information and Quality Authority stated at last officially, in print, the unspeakable truth known to all who work with and in these services:

*'In summary, of the care provided there was a:*

- *general lack of provision of basic, fundamental care, for example, not following up on blood tests as identified in the case of Savita Halappanavar*
- *failure to recognise that Savita Halappanavar was at risk of clinical deterioration*
- *failure to act or escalate concerns to an appropriately qualified clinician when Savita Halappanavar was showing the signs of clinical deterioration.*

*'It was ... noted that there were many areas where maternity service needs were not being fully met at the time of the investigation. This finding reinforces the Authority's concerns in relation to the inconsistency in the provision of maternity services in Ireland and the need to ensure that all pregnant women have appropriate access to the right level of care and support at any given time.*

*'The Authority was concerned at the absence of a national overview and structured assurance arrangements to monitor the safety and quality of maternity services in Ireland.'* [6]

These findings and recommendations scarcely begin to dig in to the chaos that characterises maternity care. Interestingly, even the Master of the Rotunda Hospital, Sam Coulter-Smith, offers a critical view (via a third

party) on this chaos. Dr Coulter-Smith has said he is concerned about the extent to which the Health Information and Quality Authority (HIQA) report into the death of Savita Halappanavar will be acted on, given past failures to implement reports' recommendations. *'There isn't accountability or responsibility attached to these recommendations. The HSE is a very big organisation; who is responsible for carrying this out, when will it be done by and where is the accountability? I would have liked to see this in the report,'* he said.[7]

**Corruption by another name: the impact of unaccountable obstetric power**

Over many years I have written extensively about the workings of obstetric power in the Irish context. However, a raft of recent events has forced me to shift my analysis to a different frame altogether. These events centred on a series of six news items which appeared in the weeks following the conclusion of the inquest for Bimbo Onanuga on 5 November 2013.

The first item had to do with the unwelcome revelation (for them), under a Freedom of Information request, that the masters of Dublin's maternity hospitals are receiving previously undisclosed private top-up payments over and above the officially agreed upon statutory limits on state salaries, and in addition to their private practices.[8] According to these reports, since amended with still further details,[7] Dr Coulter-Smith is currently receiving a total salary of €346,116 of which €60,000 comes from a 'privately funded allowance'.[8,9] An earlier Freedom of Information request in March 2013 revealed that the Board of Governors of the Rotunda Hospital had explored the possibility of renting a building in nearby Capel Street and converting it to serve as an outpatients antenatal clinic, badly needed for the over-crowded hospital. However the Board decided to suspend the idea because it was deemed too expensive in light of current financial constraints.[10]

A second item, in November 2013, reported on a newly published research study, covering 30,000 women using both public and private care in a Dublin maternity hospital between 2008 and 2011. Crucially, the same group of obstetricians led the care for both groups of women. Altogether, 34.4 per cent of privately paying mothers had a caesarean compared with 22.5 per cent of women in the public system, with the greatest disparity involving pre-planned caesareans, where 11.9 per cent of first time mothers who were going privately had an elective caesarean section compared with 4.6 per cent of those going publicly. The researchers conclude:

*'Privately funded obstetric care is associated with higher rates of operative deliveries that are not fully accounted for by medical or obstetric risk differences.'*[11]

The researchers are discreet and do not suggest what is widely acknowledged: these are financially driven outcomes.

A third story concerned an inquest which opened into a maternal death in 2012 in the National Maternity Hospital, Holles Street, in which Nora Hyland, a first-time mother, died after a 40-minute wait for a blood transfusion. According to evidence given to the Coroner, following a drop in the fetal heart rate, an emergency caesarean was carried out and thereafter blood was ordered, as the woman was thought to have lost a litre of blood. 37 minutes passed before the blood arrived in theatre. The woman's basic observations were all reported as normal before she collapsed but it was later estimated that she lost over 3 litres of blood. Consultant obstetrician, Dr Shane Higgins, was reported as testifying that the *'hospital had been unable to establish the cause of death'*.[12] The inquest may well bear out that sound procedures were in evidence, yet the continuing sense that individuals are right to distrust clinical care because of poor clinical outcomes is not without reason.

A fourth case in the High Court awarded damages of aruond €800,000 to the family of Dhara Kivlehan who died after developing HELPP syndrome in 2010. Dhara was also a first-time mother who had indications of pre-eclampsia when she was admitted to Sligo General Hospital. Two days later her baby was delivered by caesarean and she was eventually airlifted to Belfast Royal Victoria Hospital where she died. Her widower is left to bring up their son. There has been no inquest in the Republic despite the family's consistent call for one. Ms Kivlehan did not die in this jurisdiction and thus it is not known if her death will have been listed in the new Maternal Death Enquiry system in the Republic. Belatedly, an inquest will be held in the Northern Ireland. Many of the same lapses of care that the HIQA report pinpointed in relation to Savita Halappanavar were evident in Dhara Kivlehan's death. It is important to note that undiagnosed HELPP syndrome led to the death of Tania McCabe and one of her twin sons in Our Lady of Lourdes Hospital Drogheda in 2007, where, as a result of the subsequent investigation, recommendations for responding to HELPP were meant to be put in place and followed throughout the Irish maternity services.

The HIQA report on Savita Halappanavar noted the similarities between her death and that of Tania McCabe and further commented:

*'The HSE [Health Service Executive (Ireland)] reported that these recommendations were implemented at a local HSE level with regional HSE oversight. On enquiry, the Authority noted with concern that only five of the 19 maternity hospitals/units were able to provide a detailed status update on the implementation of recommendations from the Tania McCabe report.'*[6]

At the press conference following the publication of the HIQA report, Phelim Quinn, the director of HIQA, drew attention to the *'disturbing resemblance'* between Savita Halappanavar's and Tania McCabe's deaths. He stated that it was *'simply unacceptable'* that six years after the report about the latter's death, a mere five of the Republic's 19 public maternity hospitals had submitted detailed reports on the implementation of those recommendations.[13] And of course Ireland has no reliable national system of audit.

It should also be noted that in the four cases of maternal death to have come before the courts in 2013, three coronial inquiries and the High Court case for

Dhara Kivlehan – all four young, healthy women have been of black minority ethnic (BME) status: two Indian, one Malaysian and one Nigerian. This is no coincidence. The UK national confidential enquiries into maternal deaths have drawn attention to the fact for some years past that BME women have an above odds representation in maternal mortality statistics.

Finally, there were two cases within days of one another centred on catastrophic birth injuries resulting in severe cerebral palsy for a boy and a girl. It took six years and 12 years respectively to bring the two cases to court against the hospitals, the HSE and the State Claims Agency, all of whom variously denied at many points any and all responsibility for the injuries. Apologies were issued to both families at the conclusion of the court hearings, and damages totalling €11.1 million were awarded.

In summing up the case for Dhara Kivlehan, Justice Mary Irvine noted that *'this was the third case before her within the last two weeks where a defendant [the HSE and associated bodies] had "held out almost to the bitter end" before admitting liability. This was "very regrettable" and caused enormous distress to a family.'*[14]

In the 1980s and 1990s, Irish society endured a complex series of corrupt activities in three separate spheres: flagrant abuse of (then) EEC subsidies to its lucrative beef industry, undisclosed payments to serving politicians, and bribes to influence local authority planning processes for rezoning land for building. Common knowledge amongst many who colluded with these activities or who were on the edge of them, it took some time for the knowledge to come out in such a way that officials were forced to take action. In lieu of prosecuting the perpetrators of these massive frauds and putting all of them in prison, the state established tribunals at vast expense, the three largest ones costing a combined total estimated at €385 million. The perpetrators enjoyed impunity. Diarmaid Ferriter, the historian, has written of this wide-scale destruction of public trust that post-independence Ireland, prizing consensus and stability above all else, established a political culture which *'bred a cynicism and selfishness about how to do business and make money ... and a parallel devotion to a culture of self-advancement'*. Ferriter also cites a *'fundamental neglect of civic morality'* which ran alongside a snobbish and deeply hierarchical society.[15]

This society unquestioningly awarded high status to its supposed cream, the legal and medical professions, despite appalling levels of accountability and non-adherence to their public duties. During the tribunals, we saw the extent to which many in the legal profession benefited to the tune of millions, receiving fees paid from the state budget, as poachers turned gamekeepers. One of the figures heavily involved in the tirbunal on payments to politicians, Charles Haughey, as Minister for Health had awarded gold-plated contracts to hospital consultants at the beginning of the 1980s. These contracts made them state-salaried employees for the first time with full-time contracts, but with unlimited scope to carry on private practice in public or private hospitals while their public duties could absorb as little as six hours a week.[16] For obstetric consultants, this opened up an era of untrammelled and immensely lucrative private practice. It was a dangerous turning point.

In the wake of all we have come to understand in this last year about how our obstetric units and maternity hospitals function, alongside and with the HSE, it is futile to pretend that the official health and obstetric establishments, with rare exceptions, are not built on the same catastrophic dishonesty that led to the tribunals, with the same traits of collusion and secrecy which have resulted in permanent damage and loss of life for women and their babies. Irish midwifery, traditionally subservient to obstetrics in this patriarchal society, bears its own culpabilities despite a stated commitment to formally professionalise over the last 15 years.

**What we learned from Bimbo's inquest**

It took almost three years for the inquest for Bimbo to be heard. It is not mandatory in the Republic for an inquest after every maternal death, only that a report is filed with the Coroner's office. That office in Dublin is oversubscribed and has been hard pressed by cutbacks in the wake of the 2008 economic collapse. The Coroner's team may not have been fully alerted to the seriousness of the circumstances surrounding Bimbo's death from the autopsy reports for Bimbo and for the female fetus who had died at 29 weeks. Tragic as the death of any mother is, Bimbo's report appeared to be straightforward, a fundal rupture of the uterus followed by collapse and progressive coagulopathy which led to her death. But what were the circumstances leading up to that moment? An inquest is a precious public resource for a family, perhaps often without funds to engage in other legal processes, whereby they can come to understand the train of events that has led to the death of a loved person in unexpected circumstances.

What was known in outline was that an intrauterine fetal death (IUFD) was confirmed in the Rotunda on 1 March 2010, that Bimbo was prescribed and administered mifepristone prior to a planned readmission on 4 March for a medical induction, that she returned to hospital in pain on the afternoon of 3 March, and that on the morning of 4 March 2010 the first dose of misoprostol was administered. We know that two hours later she was given pethidine to manage pain and that one hour after that a second dose of misoprostol was given. Shortly thereafter Bimbo collapsed. An emergency hysterotomy/caesarean was performed in her room as part of resuscitation efforts and, after a brief spell in theatre, she was transferred to the intensive care unit of the Mater Hospital where she died later that evening.

The first day of the inquest, 18 April 2013, heard important witness statements from the Mater's consultant in intensive care medicine and from the professor of pathology at the Mater Hospital. From the latter, we learned that Bimbo's uterus had ruptured at the site of implantation, which was unusually thinned.

A further three days of witness statements and testimony followed.

The Coroner was furnished initially with depositions

from only four clinicians in the Rotunda. Bimbo's full clinical records indicated that many other clinicians were involved in her direct care. Counsel for Abiola, Bimbo's partner, pressed for, and extricated, the names of several other clinicians whose testimony was vital to have a full picture of events prior to and following Bimbo's collapse. The Coroner requested their depositions and presence, despite protestations from the Rotunda's legal team that two key people no longer worked in the hospital and that one of them had gone abroad. The Coroner patiently observed that in an era of Skype, testimony could be taken that way to facilitate the clinician currently in Australia. That was arranged for the second day, 5 July 2013. Yet more names emerged on the second day of the inquest, requiring more depositions to be sought. Under relentless questioning by Abiola's counsel, the hospital's legal team also finally released that day the rather slim critical incident report compiled after Bimbo's death, which for more than three years had been inaccessible to Abiola and to Bimbo's parents in Lagos.

By the conclusion of the inquest, there was a total of 24 depositions, 19 of which were from Rotunda staff.

The very first day of Bimbo's inquest coincided with the penultimate day of Savita Halappanavar's inquest which lasted for a fortnight. By the end of the first week of that latter inquest in Galway, the lack of basic care, let alone the shambles of disorganisation and the absence of clinical leadership had been laid bare.

Participants in the inquest were to become familiar with similar themes in the course of the four days; for example, how it becomes normalised that an off-licence drug, misoprostol, about which there are significant concerns internationally and which requires evidence-based protocols and careful monitoring when being used for an IUFD with a woman who is in the third trimester,[12,18] can be administered without even taking basic observations contemporaneously. We learned that pain for a woman in the course of a medical induction with misoprostol, but not diagnosed as associated with established labour, can be viewed as normal. Although there was consistent reassurance from the Rotunda's legal team, and from Dr Coulter-Smith personally in his testimony, that lessons had been learned and recommendations carried out, Dr Coulter-Smith did not say when changes had been made and what they actually were.

Finally, we learned about the two small acts of kindness shown to Bimbo and Abiola on 4 March 2010: the H. Dip. midwifery student who noted late in the morning that Bimbo was warm and brought a fresh jug of water in to her along with an electric fan; and the consultant anaesthetist in the Mater Hospital who responded at once to Abiola's pleas to ring Bimbo's parents in Lagos on Abiola's mobile to tell them personally that their daughter was dying.

The Rotunda learned how the African community in Dublin responded to the death of a woman most of them had never met, but about whose fate they cared very much. The representatives from the hospital had to face a public gallery with many African women in attendance each day of the inquest.

Abiola, unable to attend on the first day because of unresolved visa problems with the British Home Office (to whom the Coroner's Office wrote to ensure that he would be able to attend the inquest thereafter), learned that Bimbo's life and death and his and Nelly's loss mattered to people in Ireland whom he had never met. So serious was her condition, Nelly had not survived her mother by many months and that too mattered to people.

### A just verdict amidst many injustices

The small press coverage that the inquest attracted was accurate and fair, but the inquest did not have the dramatic appeal of Savita Halappanavar's death. I would ask questions about the sliding hierarchy of values attached to maternal deaths in Ireland. Unlike say Savita Halappanavar or Tania McCabe, a white Irish woman and a Garda police officer, Bimbo was not a middle-class professional and her death had initially been covered only by the small African press in Dublin. A Nigerian woman with the designation of 'asylum-seeker' comes at the bottom of that hierarchy of values, as shown in Carolyn Tobin's work.[19] Nelly never had a court case about her injuries nor did Bimbo receive any additional funds to help her care for her daughter.

However, Bimbo, her death, and the circumstances of Abiola and of Nelly, mattered greatly to a legal team who gave absolute commitment to gaining this inquest and to questioning all witnesses with exacting thoroughness, so that the events of March 2010 could be laid out fully. The generosity of Colm MacGeehin, Laura Horan and Dr Ciaran Craven and all their staff who stinted nothing in pursuit of the truth is exemplary. They stand out as a token of earnestness for a less corrupt Ireland in the future. The same can be stated about the Dublin City Coroner, Dr Brian Farrell, whose courtesy and care towards Abiola never wavered and whose attention to a complex series of hearings was monumental.

I know more than most about maternal deaths in the Rotunda Hospital, seeing with a different eye because of the many hundreds of detailed accounts I have read of women's deaths dating back to the 1770s. So, perhaps, I have a somewhat more historical sense of the utter cataclysm for Bimbo, Abiola, and their families and for Nelly, Bimbo's little girl, which the inquest had explored.

### Author's Note

Medical misadventure is defined as an unintended outcome of an intended medical action.[20] The work of an inquest is not to apportion blame. However, in the range of verdicts available to a coroner, this is a specific verdict about the cause of death and coroners can enter this on the death certificate for the person.

This is distinct from a narrative coronial verdict, for example, which records only the circumstances of a person's death, and does not use established categories to indicate a conclusion as to cause of death.

It grew dark as the afternoon of 5 November lengthened towards 5 pm. The lights had long since been switched on. The summaries were intricate for counsel both on behalf of Bimbo's family and for the Rotunda. Finally the Coroner took up the task of his summary and verdict. As we listened and waited, I found myself gripping the shoulder of a lovely Ghanaian woman sitting just in front of me who had so kindly attended on all four days. The Coroner's verdict of medical misadventure left people in tears. The main door being locked because of the lateness of the hour, we were led out onto the street through a side entrance to begin to absorb all that had taken place.

In the same year, two verdicts of medical misadventure[20] have been given. One delivered about Savita Halappanavar in Galway University Hospital and one about Bimbo Onanuga in the Rotunda. There can now be no mistaking the mountain of work that is required to build credible maternity services in Ireland.

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# Quotation Corner

## And breathe...

A gem from someone who is concerned about water birth:

*'It is not natural to birth in a pool filled with bodily fluids, new babies should not come into contact with bodily fluids, it is unhygienic.'*

This might be understandable had it come from someone who has not seen a birth and does not know that blood, urine and faeces are frequently present, but it came from a doctor...

## How much has changed?

Two snippets from AIMS in 1965:

**Hospital Helps**

My neighbour, who recently had her baby in hospital, was very distressed at being left alone for four hours while in labour. We both appreciate that this is due to an acute nursing shortage and wonder if we could offer our services as 'mum sitters'.

*Feb 1965*

**Crammed Hospital**

Dunfermline Maternity Hospital is so overcrowded that babies have been born in corridors, it was stated yesterday at a meeting of Fife Executive Council of the NHS.

*23 June 1965*

# Lip service and red tape

*Susan Merrick* asks if RCM practice guidance makes any difference in maternity care

**As interventions in labour and birth become more and more traditional and routine (medicalisation of childbirth) so have protocols, policies and fear of litigation. The Royal College of Midwives (RCM) guidance was originally developed and exists to underpin midwifery practice and also to 'achieve practice change' within midwifery. This guidance was, and still is, necessary due to the nature of maternity care in the UK.**

Previously the practice of obstetricians and gynaecologists was unevaluated and this impacted heavily on midwifery. The response to this was to begin to use systematic reviews such as Cochrane reviews, which were already being successfully used elsewhere. The aim of such reviews is to collect research, and in this guidance the RCM aims to use the reviews to provide midwives with evidence-based information with which to challenge routine practice that interferes with the normal birth process.

As a mother, doula and birth campaigner, I wanted to see how student and experienced midwives are guided on paper, what focus women have within this and how these guidelines compare with hospital policy and practice as we see it on the ground.

I want to briefly explore the positive elements of these guidelines and the conflicting elements within them, as well as the dilemma midwives may face when working with these guidelines alongside NICE and other policy documents. I also want to look at the language used, especially in relation to women.

The guidance is split into 20 chapters:

- Introduction
- Birth environment
- Latent phase
- Supporting women in labour
- Supporting and involving women's birth companions
- Immersion in water for labour and birth
- Understanding pharmacological pain relief
- Intermittent auscultation
- Assessing progress in labour
- Rupturing membranes
- Positions for labour and birth
- Persistent lateral and posterior fetal positions at the onset of labour
- Nutrition in labour
- Second stage of labour
- Third stage of labour
- Care of the perineum
- Suturing the perineum
- Immediate care of the newborn
- Early breastfeeding
- Guideline development manual 2012

The guidelines offer a comprehensive discussion about supporting women in normal labour and birth, using evidence that is current and that introduces some much-needed debate about current practices within maternity care. The valuable emphasis that I noted through many of the chapters was that of individual, continuous support by a named midwife and the importance of listening to the woman.

Wonderful examples of what can be done to improve normality are given, such as providing home visits in early labour, avoiding the subjective and problematic 'diagnosing' of active labour, focusing on women not measures, avoiding negative terms and avoiding interventions such as opiates, continuous monitoring, vaginal examinations (VEs) and augmentation. The guidelines also state that offering support to women often comes low down on the list of priorities in favour of technical aspects of care and that this should not be so.

It is good to see acknowledgement of evidence that suggests abandoning practice that does not promote normal birth, such as arbitrary timings of fetal monitoring, inappropriate dilation expectation, ARM to speed up labour and routine active management, to name but a few.

## The guidance also highlights the importance of midwives' attitude and language

The guidance also highlights the importance of midwives' attitude and language. In several chapters there are references to the language used with women and the effect this can have, negatively or positively, on the labour and birth as well as on the experience of the woman. There is a clear example of this in chapter 9 when discussing assessing progress. The guidance references a quote from Bergstrom et al:

*'Frequent vaginal examinations in the second stage may also "reinforce cultural messages about women's powerlessness" and imply that "the woman's body cannot be trusted to work right."'*

And it was found that:

*'Midwives have sometimes responded to the embarrassment of this situation [VEs] by adopting ritualistic semi-sterile procedures, and by using language which infantilises the woman.'*

The guidance recognises that such attitudes and use of language can cause much damage within labour and birth and to the woman who is supported.

These recommendations and practice guidance start to paint a picture of a great maternity service. However, it is one that falls far from many women's experience. So why is that?

If the evidence is promoting this good practice and also promoting the abandonment of some harmful practice, how does this transfer to the community or to the midwives practising in hospitals and birth centres?

Whilst encouraging midwives to take an individual approach to care and giving them good evidence to question habitual practice and procedures, the guidance also reminds them to document and justify ALL departures from evidence-based practice and policy. So, what about when the evidence and policies are multiple or conflicting? What happens, for example, when NICE guidance asks for arbitrary VEs to check progress or senior professionals are pushing for augmentation or intervention when a labour stalls or slows? Which guidance falls to the wayside?

What happens when the habitual or unresearched practices that are mentioned within these guidelines are policies within an NHS trust? How can a midwife challenge this safely?

**are women aware that this good practice is what they should be expecting**

Also, are women aware that this good practice is what they should be expecting? Are they aware that they should be offered this level of care? I would argue not. I would also argue that there are some midwives who do not have the time, skill or confidence to work in this way. Within busy labour wards some midwives are still being taught to manage the machinery, watch the monitors, concentrate on the paperwork and the best they can do is try to keep the woman out of the labour ward until she is at the magical 3/4cm and can be classed as in 'active labour' so as to try to avoid interventions that will come into discussion at certain arbitrary times. So I suggest that too often this is what midwives learn, instead of being able to practise autonomously, giving the individual care and support that each woman needs and that is recommended as best practice.

What can be of real help to midwives here is the women themselves. It does seem to be forgotten within the realms of policy, procedure and recommendations that ultimately these are the choices of the woman. It is up to her to give informed consent to every single one of these procedures and practices. The woman must consent for you to support her, she must consent to you being present and to you touching her. If a woman does not consent to something, then the midwife has the justification she requires for her documents.

However, this requires women being informed and being aware of their rights in maternity.

A phrase that stands out for me in the guidance introduction and several other places is that women are to *'be involved in decisions'*. To be involved is not suggesting, as it should, that women are the decision-makers. They are only consulted. This type of language can detract from any other good practice that is recommended. If midwives are not taught, and constantly reminded, that women are the centre of maternity, that they make ALL the decisions about their bodies and their care, then midwives will continue to practise without this in mind. The midwives and professionals involved may give the information and guidance but they should not be making the decisions. An example of this can be found in chapter 17 when the midwives are guided to *'explain to the woman what they plan to do and why'*. This does not remotely suggest that they should ask for permission.

A consistency of language is important within such influential guidance. Many of the chapters do speak clearly about the woman being the decision-maker, but this varies in other chapters and can minimise the role of the woman.

The philosophy underlying these guidelines is one of good practice to promote positive normal labour and birth for women. Where midwives have the time, autonomy, experience, skill and confidence to listen fully to women, know the women and provide individualised care, these guidelines can be considered extremely beneficial. Where midwives have less autonomy, confidence, experience and medicalised training and where protocols, time restrictions, busy shifts and fear prevails I ask if it really possible for these practice guidelines to be implemented.

I would like to see more women having access to this information themselves, to gain more of an idea as to what they should expect from their care, with normal birth as described in these guidelines truly becoming the normal practice and experience rather than the exception.

*'In all situations, it is important that women understand who has responsibility for their care and that they remain informed and involved in decisions about themselves and their babies.'*

And again, I remind those reading that the ultimate responsibility lies with the woman herself.

If the practice recommended in this guidance is what evidence shows is best, what midwives want to achieve and what women want for themselves, then please, please let's find a way to use it to truly implement good care.

*Susan Merrick*

The RCM practice guidelines 2012 are available at www.rcm.org.uk/college/policy-practice/evidence-based-guidelines/

# Evaluating technology

*Jo Dagustun* offers a geographical appraisal of the birth pool

**Current western culture has become brilliant at 'denormalising birth'. The sheer possibility of the physiological process of birth actually working is eroded, it seems, at every turn. This leads to women seeking increasingly inventive ways to preserve normality whilst birth culture looks for ways to turn those self-help measures into interventions.**

These inventive ways that support the physiology of birth are frequently taken over by systems and then used to control rather than support women.

In some areas of the UK water has become a taken-for-granted part of the repertoire of birthing mothers and midwives oriented towards achieving normal birth, and new possibilities are opened up by this new type of birthing space. In other areas there is resistance to the use of birth pools.

So many birthing technologies are introduced without good quality, or even any, evaluation. Research on the use of birth pools shows positive outcomes,[1] but some would argue that high quality evidence is still needed.[2,3]

From a purely biological perspective, despite some speculative work done around our mammalian links to underwater birthing practices as exemplified by dolphins, there is nothing to suggest that humans giving birth in water is 'normal'. However, babies have long been born in baths after their mothers spending part of labour in a nice hot tub of soothing water.

The practice of labouring and/or giving birth in water regularly crops up in the context of the promotion of 'normal' labour and birth: in journals and magazines aimed at researchers, professionals and pregnant women; at antenatal classes and homebirth support groups; at academic conferences. In parts of the UK it is rapidly becoming part of the 'working with pain' tool-kit of midwives oriented towards supporting normal birth, and for women seeking to avoid pharmacological pain relief, wherever they are planning to give birth. However, in many places women are not getting information and there are still unfounded concerns about things such as babies drowning. All too often women are advised against using water unless their pregnancy and labour fit a very narrow range of normality.


Fiona Willis in the birth pool with her daughter Tara

In some places medical resistance to this particular initiative has been fairly muted; in others (particularly Ireland and the US) there has been vociferous and sustained obstruction to using birth pools. Paediatricians have raised some concerns about possible negative consequences of water births on neonatal lung function, but research evidence on that and other fears has been inconclusive. Other research shows that labouring in water does indeed provide pain relief and reduces the numbers of women having epidurals.[2]

While practical debates continue about how to resolve some key barriers to the practice, the notion of 'allowing' women to labour in water has finally been accepted in most areas of Britain, although even where it has been accepted there is not always whole-hearted support for actually birthing in water. Remaining barriers to the widespread availability of birthing pools include: cost and space; training needs for staff in supporting the use of a pool; local health and safety clearance for the use of a pool in the labour suite; debate around some detailed protocols for the 'intervention', such as who is and isn't eligible to use the birthing pool; at what stage of her labour should a woman be 'allowed' to access the pool; what are the indicators that suggest the need to get a woman out of the pool. Practical and control issues aside, in places we can see that the installation of birth pools on the labour ward is now a mainstream part of any well-funded refurbishment project, with birth pool equipment businesses flourishing and projects to support access to birthing pools for use at home widespread.

It has become clear that the use of birthing pools in labour and for birth represents the introduction of a significant new and unique kind of birthing space.

As a geographer investigating contemporary UK childbirth culture, I'm extremely interested in the growth of the birth pool phenomenon. Yes, the birth may still be taking place within the walls of a traditional birth setting, but whether this is on the consultant-led maternity ward, in a midwifery-led birth centre or at home, such a new water-based space has potentially far-reaching consequences for the performance of birth itself.

Women are often drawn to water because it affords them more privacy, it creates focus, it increases mobility, eases strong sensations and aids relaxation. The water

both represents and physically ensures a barrier. Very few medical professionals don their swimsuits and get into the water with the mum-to-be.

By situating herself within the birthing pool environment, the labouring woman immediately distances her body from those outside the pool. In doing so, a new boundary, border or space of exclusion is constructed, within which the woman can be alone with her body, and move freely, and rapidly perhaps, to avoid unwanted touch, much more effectively than might be possible on land. This must surely focus the mind of all those involved, if they are open to such ways of thinking, on which hands-on interventions really are important to the well-being of mum and baby.

During the moments when the baby is being born, the water-based venue lends itself well to the mother (or her chosen birth partner) playing a primary role in 'catching' her own baby – something that is far harder to achieve in land-based births.

I am not suggesting that these implications are the explicit goals of the individual women who choose to labour or birth in water: personal goals will be many and varied, as will the nature of the support a woman receives whilst using a birthing pool, but the birth pool creates fundamentally new spaces of birthing. It opens up new possibilities for how the birth performance can be imagined and enacted.

This is a space where healthcare professionals might be supported in developing an increasingly confident hands-off approach to birth, and where a mother may achieve a far greater degree of autonomy over the birth of her baby and how her baby is, quite literally, handled at and immediately after birth. Indeed birthing your own baby in water, even with a midwife in the room, may present a non-disturbed birthing scenario for women who wish to prioritise respect for the body's amazing physiological ability to birth.

So far so good, but I'd like to share two aspects of all this that continue to trouble me. Is there a danger that women will feel obliged to use a pool in order to avoid unwanted interventions, instead of practitioners examining how women can be less disturbed overall?

Is there also a danger that birthing pools morph into yet another in a long line of childbirth technologies which individually and collectively over the years have worked to send a powerful signal that birth is outside the competence of ordinary women; that women's bodies are weak and bound to fail? What if the birthing pool is absorbed into yet another in a long list of interventions that, whilst intended to help a woman cope with pain in labour, actually reinforce the notion that women are not expected or able to work with their bodies' various signals about the ongoing physiological process of birth, sometimes known as pain, in order to achieve a good outcome?

What if the birth pool as a simple and effective tool used by women to gain privacy and autonomy as well as pain relief becomes hijacked by technology and evolves into something too complex for a woman in labour to own or have control over? It is already happening, with pools being designed with cut-away places where a professional can get physically closer to the woman or get a better view of the birth, and pools with numerous mechanical controls and equipment attached. The 'rules' that have already become attached to labour and birth in water serve to prevent a woman having control over her environment rather than encourage it, such as having to reach a certain stage of labour or dilation (diagnosed by some test or standard other than the woman's own need or desire for water).

In the context of the sustained undermining of women's confidence in their abilities to birth, over several generations, this raises the inherent challenge of giving positive messages about birth and women's innate ability to labour and birth while at the same time acknowledging that some practices might help women.

Enthusiastically promoting birth pools, hypnotherapy, TENS, aromatherapy, massage and other means of supporting physiology and normal birth – unless the key message is that women can do birth – can imply that women can only birth by using props.

How can we best retain the incredibly positive practical consequences of birthing pool technology on our own terms? How can we make use of this technology whilst avoiding the reproduction of the powerful cultural messages around women's inability to birth? Those highly influential cultural messages have, I believe, been a problematic part of dominant birth discourse for far too long, and our societal health pays the price. The more we can reflect on our own potential contribution to them, by everyone of us in our everyday lives, the better chance we may have of dismantling them.

*Jo Dagustun*

*Jo is currently a PhD candidate in the School of Geography, at the University of Leeds. Jo has birthed four babies, none of whom was born in water, although Jo is the owner of a birth pool (aka very large paddling pool – remember the early versions?) and has spent some time over the years labouring in a bath, both at home and in hospital.*

*Jo can be contacted at gyjwd@leeds.ac.uk.*

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# Which? Birth Choice

*Miranda Dodwell* introduces a new website providing information on local maternity services

**The website (www.which.co.uk/birth-choice) is the result of a year-long project working with Which?, and a longer history of providing information to women about choosing where to have their baby.**

The original BirthChoiceUK website, launched back in 2001, was created as a result of my experience facilitating antenatal classes. I realised that women were not receiving all the information they needed from health professionals to decide where to give birth. They were unaware of the benefits of continuity of care, and of how to avoid getting fragmented care by choosing particular birth options. The BirthChoiceUK website was designed to help them understand the implications of different choices and provide information, including statistics for maternity units around the UK, so that they could make a more informed decision.

My colleague, Rod Gibson, and I developed and maintained the website on a voluntary basis. Over time, however, the website became outdated and needed fresh investment. It was therefore very exciting to be contacted by Which? asking us to collaborate on a new website helping women explore their birth options.

For us, Which? was a perfect partner – an independent consumer organisation with charitable objectives and a trusted brand which was keen to do more to help the consumers of public services. BirthChoiceUK's reputation for maternity data, experience of running a website and knowledge of maternity services made us the ideal partner from Which?'s point of view.

Choosing where to give birth is a hugely important and personal decision. Pregnant women need specific information to help them understand the different choices available to them so they can make the right decision. The heart of the Which? Birth Choice website is the interactive 'Find and Compare' tool where pregnant women answer questions about where they live, their own preferences for birth and their circumstances (such as age and previous birth history) to find out which options are their 'best fit'.

For a woman at low risk of complications, this tool combines her preferences with evidence from the Birthplace Study to show her the birth settings (such as home, birth centre or labour ward) most suited to her, as well as their location in relation to where she lives. Women who are actively trying to avoid interventions are recommended to plan birth at a distance from a labour ward. For all low-risk women, the default option will be a birth centre or at home, as the Birthplace evidence shows that these are the safest places to give birth (with additional information given to first-time mothers about increased transfer rates and about the slight differences in safety for the baby at home). Recommendations will be affected, however, by a woman's strong preference for giving birth in a clinical environment, with doctors nearby, or for an epidural.

Women who self-report that they are at increased risk of complications and show a preference for birth in a clinical setting or for an epidural will have a labour ward suggested as their best fit, in accordance with guidelines. However, other options will be flagged where women indicate by their preferences that this is not the type of birth they want. For these women, information is given to help them negotiate appropriate care either in a labour ward, in a midwife-led setting or at home, with details of individuals or organisations (including AIMS) that can support them in their choices.

To ensure that it is an effective tool, we consulted carefully with the wide range of maternity experts on our Review Board and tested it out thoroughly with a variety of pregnant women.

Another area of the website – Understand Your Choices – helps women explore the differences between different birth environments and to compare them side by side. Each maternity unit in the UK also has its own profile page giving information about their facilities and policies in place. This includes details on how to arrange a home birth, how reliable the home birth service is, and home birth rates for that hospital. This information has been collected from Heads of Midwifery themselves, with the help of the Royal College of Midwives, and we have had a great response rate. However, if data on your local maternity unit are missing, then please do urge the Head of Midwifery to complete our questionnaire.

An innovative feature of the site is the presentation of personalised maternity statistics, based on whether a woman has given birth before and whether she is at low risk of complications. In the same way, women who have had a previous caesarean can see the rates of repeat caesareans and of vaginal birth after caesarean (VBAC) at different maternity units. The website also offers the opportunity to 'Learn More', with a variety of articles on topics such as the importance of continuity of care and coping with pain in different birth settings.

You can find the Which? Birth Choice website at www.which.co.uk/birth-choice. Use the menu buttons to access the 'Find and Compare' interactive tool.

We are very grateful to the members of the AIMS committee who have reviewed the website for us and made suggestions for amendments. If you have any feedback on the site, you can contact us via birthchoice@which.co.uk.

*Miranda Dodwell*
*founder of BirthChoiceUK*

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# Personalised maternity care?

*Emma Ashworth* reports on the Health Education England meeting, 28 February 2014, Leeds

**Personalised maternity care stakeholder events, hosted by NHS Health Education England, are being held around the country in response to a request from the Permanent Secretary for Health, Dr Dan Poulter, to explore the ambitions for future maternity services and what they might look like by 2022.**

I came home with a headache, partly due to immense blood pressure spikes from time to time, not least listening to an obstetrician using the phrase 'rescuing women' TWICE in his talk, and calling obstetric services 'rescue services'.

I sat with One to One midwives and the two consultant midwives from Wakefield, plus someone from the RCM, and on the whole found the meeting to be very enlightening in terms of understanding some of the future of maternity care in England.

### Lisa Bayliss-Pratt
### Director of Nursing, Health Education England

Lisa talked briefly about success criteria for change being improvements in clinical outcomes. I thought that solely looking at clinical outcomes was really missing the point, given that, as we all know so well, there are so many other outcomes which are non-clinical, but just as important to the longer-term mental and physical health of mums and babies.

Unfortunately there was no opportunity for questions so I was unable to make this point, although fortunately it was clearly raised in later presentations. Lisa said that most NHS maternity funding goes into the training of obstetricians.

### Birte Harlev-Lam
### Head of Maternity and Children's Services, NHS England

Birte did make the point that there were lots of new midwives being trained, but not enough jobs for them. Every time Dan Poulter is interviewed about the shortage of midwives, his answer is that there are 5,000 midwives in training, yet he consistently fails to mention that in fact there will be few jobs for those midwives once qualified, so it is a weasel answer.

Birte said that there was an exclusion from the legal right of a patient to any other provider within maternity, mental health and cancer services. However, a representative from One to One Midwives said to me that they have had some clarity on that and it wasn't legally supportable. Birte said that, according to some research they'd done, 'On the whole, women are "reasonably happy".' A delegate queried this at the end, pointing out that in the private sector companies would not feel that customers, on the whole, being reasonably happy, would be acceptable.

The analogy that came to me too late was of parachute-packing companies which at least wouldn't have customers left to complain if they were only 'reasonably happy'! Brenda from Independent Midwives UK (IMUK) pointed out that Clinical Commissioning Groups (CCGs) can still commission Any Qualified Provider (AQP), even if they're not legally obliged to.

### Lesley Page
### Royal College of Midwives (RCM)

Lesley claimed that we are 'hugely privileged' within the UK. She talked about the Birthplace Study, and gave some good information on homebirth and midwifery-led units (MLUs) having a lower risk of caesarean section and other interventions. She said that the RCM 'still wants to support normal birth' but wants to look at models for women who have complex pregnancies. There was no clarity about what this meant, exactly, and it will be interesting to see what choices the RCM makes over the next months.

Lesley went on to talk about how Middlesex Hospital gives out gold stars to midwives and doctors who receive good feedback from the friends and family rating. I was personally disappointed that this was the best example of best practice she could come up with, although it did seem to be something that those involved in the trial felt was valuable. While 'every little helps', the general consensus on our table was that we had expected examples with more substance.

## Only 12% of women know their midwife in labour

Only 12% of women know their midwife in labour, and, she said, access to MLUs should be widened. Perhaps that is what she means about looking at models for women who have complex pregnancies? This could be brilliant if the RCM is going to actively support it. She also said that any maternity improvements must respect the contribution of midwives – such as improve working practices and management practices. If only!

Lesley said that the Birthplace Study said that low risk women should have a choice of place of birth. This, it was pointed out in the questions, was not accurate, and aside from access to Trust property such as birth centres, women of any 'risk' have the choice, enshrined in law, to birth where they want to. Lesley conceded that this was so, but then went on to say that while this is true, in her experience with the right care, women will do 'what is best for them'. Another questioner pointed out that some women are not given the choice and end up having to birth alone, and Lesley again said, 'sometimes women

need help to make their choice'. A third questioner made the excellent point that commissioning is fragmented and the tariff doesn't reward continuity, and this was discussed and agreed.

Barbara Kuypers, project lead for the day, then said that women need to understand that when they are asking for care outside of midwifery-led care it's out of the midwife's remit.

**James Walker**
**Royal College of Obstetricians and Gynaecologists (RCOG)**

I was not the only person to find this speaker very difficult to listen to. He spoke a lot about 'rescue services' (obstetrics) and how they must not be taken away, which is an absolutely pointless straw-man argument as no one is for a moment suggesting that we should be taking obstetric care out of the equation for those women who need it. He used the phrase 'rescuing women' several times. He also said that midwives need to understand abnormality, not just normality, as though midwives were not highly skilled and experienced in both. All of the midwives on my table bridled strongly at this.

He went on to AQPs and said that it's important that they're regulated and that the problem is that it's cheaper for them to run their businesses without training their staff. I believe that he was intentionally undermining the idea of AQP to the commissioners. A representative from One to One said that AQPs have to be registered with the same bodies as the Trust providers, and regulated the same, and trained the same.

**Sheena Byrom**
**Midwife and author**

Sheena spoke next, about the lack of evidence base in maternity care and how change is long overdue. I enjoyed her talk so much that I made few notes, apart from the comment that I agreed with her! Fortunately Sheena has summarised the talk she gave on her website sheenabyrom.com.

**Carmel McCalmont**
**Associate Director of Nursing and Head of Midwifery, Coventry**

I really struggled to understand what point Carmel was making because she talked a lot about non-evidence-based care they'd done (something about turning a woman on her head to avoid miscarriage?) and then she said that when the woman got to the end of her pregnancy she [Carmel] went in to birth her baby. She mentioned this a few times: how other midwives on her ward birthed babies for women, 'This is a photo of Alison, with the baby she's just birthed'. This is a personal bugbear, as of course women birth their babies, not their care givers! I think the point she was trying to make was that woman-centred care (a phrase I detest, given that the entire purpose of maternity services is to give care to women) wasn't necessarily going to be to guidelines, which I absolutely agree with, but I felt that her point was poorly made, unfortunately.

**Belinda Phipps**
**CEO, NCT**

Belinda discussed how it was a real problem in labour wards to staff appropriately, and therefore it made sense to staff the women, not the ward (continuation of carer/community midwife coming into the labour ward). She talked a lot about continuation of carer, and a questioner at the end asked, 'Given that the biggest campaign at the moment on this area is M4M, is the NCT going to support it?' She replied that they had supported it, signed up to it and funded it. She was then asked if the NCT was going to actually share the information with its members (as there has been virtually no use of NCT members or branches to support this vital campaign, despite that being the huge value of NCT to the campaign, thus losing a massive opportunity for change). She replied that M4M was an organisation run by mums and it was more appropriate for NCT to be in the background, and anyway M4M had probably done its job and will likely be no longer needed. I was extremely disappointed in this answer. M4M is an active and essential campaign. Whilst I would be delighted for it to no longer be needed, I felt that this was Belinda stepping the NCT away from the campaign rather than an accurate reflection of the fact that we now have a 'Midwife 4 Me and My Baby'. In my opinion the NCT lost a great opportunity to support this vital campaign through its networks which it never did in any meaningful way.

I chatted a bit, in the break, with a couple of consultant obstetricians who were talking freely about defensive 'care' (isn't that an oxymoron?) being essential in their work. I think this is something that we in AIMS really urgently need to address: firstly, making sure that it is very clear to women who we communicate with that this is happening, and secondly trying to see if we can come up with suggestions of how clinicians can protect themselves without causing more damage. So for instance, instead of putting the fear of God into people, perhaps coming up with ways that they can word information so that it's true information sharing.

*Emma Ashworth*

The Twitter hash tag from the day is #pmcare2014

For more information on Health Education England Health Education England visit hee.nhs.uk

## M4M
## A Midwife for Me and My Baby

We want every woman to have a midwife that she can get to know and trust, who can support her through her pregnancy, birth and beyond, regardless of her circumstances or where her baby is to be born.

For more information on M4M, please visit www.m4m.org.uk

# Birth and the future of Homo Sapiens

Hypnobirthing Association 'Sharing Day' – Michel Odent. 1 March 2014, King's College London

**Michel Odent has been a visionary and inspiration for birth workers and parents for over 35 years and, now in his 80s, he still has the ability to bring key issues into sharp focus.**

His ongoing research into the 'Primal Period' and subsequent health and well-being is of vital interest and importance, and his ability to speak to and engage an audience (strong French accent notwithstanding) is as strong as it was when he emerged as a public figure, thanks to the BBC, in the early 1980s. If you haven't yet read or heard Michel Odent, rectify that as soon as you can for he is able to explain complex issues clearly and succinctly and his enthusiasm for his subject is infectious.

The Hypnobirthing Association Sharing Day, organised by KG Hypnobirthing, consisted of Michel outlining some of his key concerns, particularly the rapid diminution in oxytocin release over the last 40 years and the possible epigenetic consequences of this phenomenon. Not only does the use of synthetic oxytocin, caesarean section and actively managed third stage mean that the hormone of love is reduced perinatally, but he suggests that the reduction in the birth rate and the shortened duration of breastfeeding mean that our oxytocin system is under-used and may be weakening, with consequences for humankind. Michel also discussed the changing bacteriological environment of birth and its possible long-term effects. He made a plea for us all to protect the involuntary process of birth from inhibitory factors, and outlined the importance of the suppression of neocortical activity during labour.

Michel talked for most of the morning and then addressed the audience's questions in depth through the afternoon. The audience comprised hypnobirthing teachers, student midwives, doulas, some parents-to-be and a few midwives. It is a shame that not many midwives and no doctors attended, as the day was excellent value and really got to the heart of what is important about birth and the responsibility attendant on working in the field. Oxytocin is beginning to receive some attention even in conservative obstetric and midwifery circles. The radical impact of what understanding its role and nature means for birth practices has, however, as yet, barely been perceived. Michel Odent's message is that the physiology of birth has far-reaching implications for us all, which we ignore at our peril.

*Deborah Hughes*

# The face of birth

Where the Personal gets Political – An Australian documentary about pregnancy, childbirth and the power of choice

**This film offers an excellent portrayal of the issues that travel to the very core of discussions about women and giving birth.**

There are interviews with a variety of mothers who have given birth in Australia and in the UK, interspersed with childbirth educators, obstetricians, midwives, midwifery lecturers, childbirth activists and indigenous Aboriginal birth attendants among others.

The interviews are woven together in such a way that many of the complexities in the provision of maternity care both within Australia and in the context of the wider world are eloquently portrayed.

Some of the topics covered are:

- The political debate about where to give birth, home or hospital, comparing the current situation in Australia with that of the UK.
- The qualities women need for normal physiological birth.
- How in Australia one in ten babies born to healthy women by caesarean section will be admitted to neonatal intensive care. There are long-term health implications for those children born by caesarean section.
- one in six new mothers in Australia develop mental illness and postpartum depression and suicide is rising.
- A shocking one in ten childbearing women who die in Australia do so by their own hand.
- Traditional Aboriginal midwives Lena & Rosie, they 50 years of practice and have never had a breech delivery. They use massage on the woman's belly to help straighten the baby's position ready for labour and birth.

One of the key points made is that a 'willing woman' who wants to give birth with minimal intervention is now considered counter culture.

I highly recommend this film to anyone who is interested to hear from a wide variety of people associated with childbirth and to learn more about the political, social and cultural context of birth with a view to raising issues for changing the Australian maternity care system. This film also has wider, more universal points to make about birth in general.

*Olivia Lester*

*Rated PG. Running time 87 mins.*

# Anti-D

*Nadine Edwards* shares some vital information for informed decision and protocol making

**This readable, open access paper discusses the potentially unnecessary use of anti-D during pregnancy.**

Its authors suggest that, each year, about 40,000 women in England and Wales who are rhesus negative receive anti-D unnecessarily, because they are pregnant with a rhesus negative baby. They acknowledge the benefits of anti-D over the years, but question its routine use when there is now a 'non-invasive' test available to see whether it is needed or not. They say about the test that:

*'it has been shown to be very accurate but the small possibility of false negative results remains. If the test gave a false negative result and routine cord blood phenotype testing at birth subsequently identified the fetus as RhD positive then postnatal Anti-D Ig would still be administered at that time, but potentially sensitisation could occur in these women affecting subsequent pregnancies. The risks of this happening have been estimated to be 1:86,000.2.'*

In other words, while no test is 100% accurate, the likelihood of a false negative result and subsequent sensitisation is extremely small – one in 86,000.

The authors also describe how anti-D is produced in North America:

*'a blood product made from pooled plasma, it is collected mainly from RhD negative men who are injected with RhD positive red blood cells, so that they produce antibodies. The men are paid a "premium" because of the risks they face when being injected by donor red blood cells.'*

This is a useful paper, because accurate and reliable information about anti-D is not easily available to pregnant women who are rhesus negative, and despite concerns about receiving blood products, most are told that anti-D is necessary and that it is given routinely during pregnancy, and that not having anti-D could result in problems for their babies. As Sara Wickham points out:

*'There isn't nearly enough research about how anti-D may affect the unborn baby. Moreover, a proportion of the women who receive antenatal anti-D do not need it because they are carrying a rhesus negative baby, and therefore the problem that anti-D is given to prevent simply didn't exist in the first place for these women. In the UK, this proportion is estimated to be around a third of rhesus negative women.'*[1]

The authors rightly question the ethics of injecting women with a blood product during pregnancy that around 40,000 of them each year in England and Wales do not need, when there is now a reliable test available that would prevent the need for this.

### References

1. www.sarawickham.com/riffing-ranting-and-raving/how-to-save-40000-women-a-year-from-having-an-unnecessary-blood-product/.

**Julie Kent, Anne-Maree Farrell and Peter Soothill (2014) Routine administration of Anti-D: the ethical case for offering pregnant women fetal RHD genotyping and a review of policy and practice. BMC Pregnancy and Childbirth 2014, 14:87. doi: 10.1186/1471-2393-14-87**

## Abstract

**Background**

Since its introduction in the 1960s Anti-D immunoglobulin (Anti-D Ig) has been highly successful in reducing the incidence of haemolytic disease of the fetus and newborn (HDFN) and achieving improvements to maternal and fetal health. It has protected women from other invasive interventions during pregnancy and prevented deaths and damage amongst newborns and is a technology which has been adopted worldwide.

Currently about one third of pregnant women with the blood group Rhesus D (RhD) negative in the UK (approximately 40,000 women per year in England and Wales), receive antenatal Anti-D Ig in pregnancy when they do not require it because they are carrying a RhD negative fetus. Since 1997, a test using cell free fetal DNA (cffDNA) in maternal blood has been developed to identify the genotype of the fetus and can be used to predict the fetal RhD blood group.

**Discussion**

This paper considers whether it is ethically acceptable to continue administering antenatal Anti-D Ig to all RhD negative women when fetal RHD genotyping using maternal blood could identify those women who do not need this product.

**Summary**

The antenatal administration of Anti-D Ig to a third of RhD negative pregnant women who carry a RhD negative fetus and therefore do not need it raises important ethical issues. If fetal RHD genotyping using maternal blood was offered to all RhD negative pregnant women it would assist them to make an informed choice about whether or not to have antenatal Anti-D Ig.

# Birth control

*Gemma McKenzie* looks at research on women's experiences of informed decision making

**Rachel Thompson and Yvette Miller (2014) Birth control: to what extent do women report being informed and involved in decisions about pregnancy and birth procedures? BMC Pregnancy and Childbirth 2014, 14:62 doi: 10.1186/1471-2393-14-62**

### Methodology

The researchers sent a survey to all women who had, within a four-month period in 2010, a live birth in Queensland, Australia, and who had experienced one of the following procedures:

Ultrasound scan (for any reason)
Blood test (for any reason)
Induction of labour
Pre-labour caesarean section
Vaginal examination during labour
Fetal monitoring during labour
Post labour caesarean section
Epidural
Episiotomy

The researchers included women who had both singleton and multiple pregnancies. They did not include, in their analysis of caesarean sections, women who had given birth to twins where one had been born vaginally and the other by caesarean section.

## women's perceived receipt of information

The survey contained questions that assessed the women's perceived receipt of information about the benefits and risks of the procedure and their role in decision-making about that procedure.

The questions were very basic. When surveying the receipt of information, the question required only a yes/no answer as to whether the medical professionals had discussed the pros and cons of the procedure with the woman. The woman's role in decision-making was assessed by asking who decided that the woman would undertake a particular procedure. The potential responses were:

*I decided from all my available options;*

*My maternity care provider(s) decided and checked it was OK with me;*

*My maternity care provider(s) decided without checking with me.*

### Results

The results showed that out of 3,542 women who completed the survey, many underwent procedures that they had neither been informed of nor consented to. Some of the statistics are as follows:

60% of the women had not been informed of the benefits and risks of vaginal examinations;

13% were uninformed and unconsulted about the vaginal examinations they experienced;

26% were neither informed nor consulted about their episiotomy;

19% had not been consulted or informed about the fetal monitoring of their baby;

48% had not been informed of the benefits and risks of ultrasound scans;

14% of women underwent a caesarean section without being informed of the benefits and risks associated with the procedure.

One of the important points that emerged from the study is that women felt least informed and consulted about the procedures that were most routinely carried out (ultrasound scans, blood tests, fetal monitoring and vaginal examinations). Worryingly, this suggests that once a procedure becomes routine, it undermines the process of informed decision making.

### Limitations of the study

The researchers acknowledge that there were some limitations to their study. Firstly, only 34.2% of the women they asked completed the survey. Arguably, a higher response rate could have produced different results, or at least more reliable results.

Secondly, the researchers admit that they adopted a *'crude measurement of potentially complex decision making processes.'* This was done partly because they wanted to carry out large-scale data collection and also so as to capture the experiences of a range of people, including those frequently unconsulted in research. However, this process does create somewhat of a grey area around the respondents' perceptions of the information they received and the decision-making process associated with that.

Finally, some of the respondents did not complete their survey until up to a year after the procedure took place. This means that there may be some question mark over the accuracy of the respondents' recall of events. The researchers do, however, cite research that highlights how women typically recall their maternity care experiences with great detail even years after they have given birth.

Discussion points

In some respects, this research throws up more questions than it answers. One point to note here is that the researchers only assessed a woman's perceived receipt of information. If a woman is receiving all of her information from a medical professional and not looking at relevant literature or research herself, then she cannot be sure her care provider is giving her the full picture. The researchers, therefore, were not assessing whether the woman actually got the correct information to enable her to make an informed decision, but whether she believed that she was getting all of the relevant information. In other words, they were not researching how well informed the women actually were, but how informed they felt they were. This is highlighted in the example question given in the paper:

*'Did your maternity care provider(s) discuss with you the pros and cons (benefits and risks) of having and not having a caesarean?'*

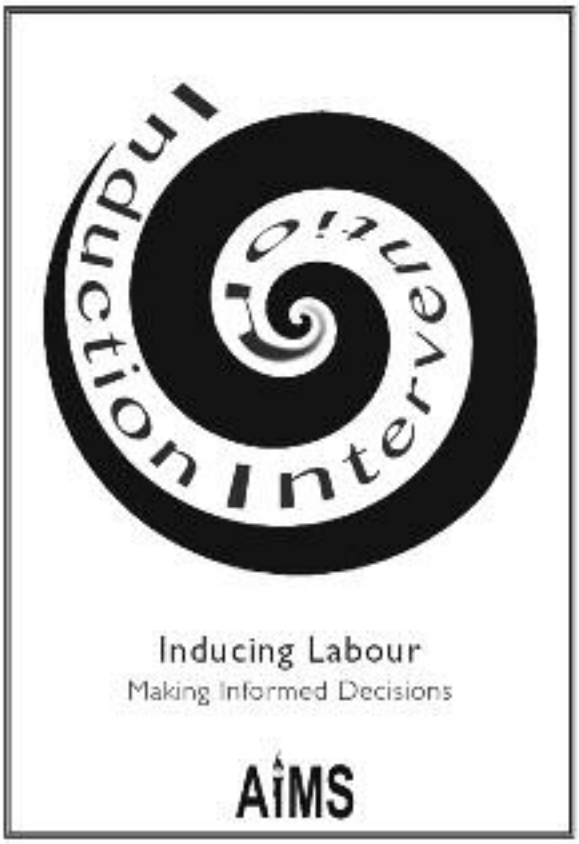
Questions of this type presuppose that the care giver is able and willing to give a woman the full picture and that she is in a position to assess whether all of that information has been given to her. Of course, this is not always the case; therefore even for those women who answered 'yes', it is questionable whether they were truly 'informed' in the strictest sense of the word.

The type of information a woman is given may also depend on the position of the care giver and his or her perception of what is 'normal'. Statistics given in the paper show that 94.7% of the respondents who laboured had experienced fetal monitoring. Forty percent of all of the respondents had given birth via caesarean section. Further, 24.9% had been induced; 38.3% had had an epidural and 19.1% were subject to an episiotomy.

Most notably 98.1% of all births were in hospital and only 0.1% were planned homebirths. This suggests a medicalised maternity service in which intervention is the norm. In turn, this begs the questions of how up to date the care providers were on the research on procedures and whether their perceptions of a normal birth would result in a woman not being given all of the relevant information so she could make an informed decision. In addition, it could explain why many women felt they had limited or no input into the decision-making process and the interventions they experienced. Perhaps, due to the frequency with which these procedures are taking place, they are slipping into the 'routine' category and medical professionals are feeling less need to discuss benefits and risks in detail or to fully gain the woman's agreement.

The last point to note is that a blank is drawn on how many women gave birth without any interventions whatsoever, as they would not have received the survey. Given that blood tests and ultrasounds are now routine aspects of antenatal care, it is unlikely that there would be many such women, but it would be interesting if the researchers had tapped into those women's experiences to see whether they had felt fully informed and therefore empowered to opt out of medical procedures.

*Gemma McKenzie*




# Inducing Labour

## Making Informed Decisions

AIMS is delighted to announce the publication of Inducing Labour - Making Informed Decisions, which replaces Induction - Do I really need it?

The book has been fully revised by midwife, researcher and former editor of Essentially MIDIRS, Sara Wickham.

It is a must-have for all those who are supporting women in their decision-making process and it is a great read for women who are exploring their options and the research behind them.

Written in a friendly and accessible way, with a look at relevant research and information, this book is easy to read and easy to absorb, and whilst the language is easy to understand for both professionals and lay readers alike, there is no stinting on or glossing over the information.

The book is available from www.aims.org.uk or by emailing publications@aims.org.uk.

# Face to face with the GMC

An Open Letter from *Michael D Innis*

**It was difficult, Niall Dickson, Chief Executive and Registrar of the General Medical Council (GMC) said, for the GMC to investigate poor clinical practice unless the case was referred to them. Patient protection, he emphasised, was what the regulatory process was about, not the punishment of erring doctors.**

And so I draw the attention of the GMC to the effect of poor clinical practice.

First let me make it clear. My intention of reporting this case to the GMC is to disclose what is a patently absurd medical diagnosis which is destroying the lives of hundreds, perhaps thousands of innocent and loving carers – the diagnosis 'Shaken Baby Syndrome'. This diagnosis by a group of medical professionals resulted in Judge Mr Justice MacDuff sentencing Darryl Elliott to life imprisonment for the murder of his partner's baby Amelia Bowmar.

He said: *'You have been convicted, on overwhelming evidence, of the murder of Amelia Bowmar, a little girl of 14 months whose care had been entrusted to you by your partner; her mother. Your job was to look after and protect her but, instead, she died at your hands.*

*'It is clear to me that because you perceived her to be misbehaving, or perhaps because you had to deal with her when she was sick, or just because you lost your temper at something wholly unconnected with her behaviour, you so violently and deliberately shook her as to the catastrophic injuries from which she died. Only you know exactly what went on inside that house on July 28 last year.*

*'I accept that this was a spur of the moment loss of temper and also that you did not intend to kill. I also accept that you were immediately full of remorse – although that remorse has to be seen alongside an attempt to distance yourself from what you did and a failure to acknowledge your responsibility. Your failure to tell the truth in those early hours meant that the medical teams spent time investigating other possible causes. I am satisfied that Amelia was so seriously compromised that she would have died anyway. But you were not to know that.'*

How was the learned Judge to know that it was not Darryl who was not telling the truth and the diagnosis 'Shaken Baby Syndrome' was a fabricated diagnosis without the slightest scientific evidence being propagated by doctors whose seem incapable of understanding that Amelia had a disorder of the coagulation system as shown by a raised INR of 1.3, and APTT of 39.6.

This would explain the brain and other haemorrhages but the evidence was ignored by the doctors alleging murder. Until doctors learn that an abnormal PT, APTT or INR means that bleeding and fractures are inevitable false allegations of shaken baby syndrome will continue.

Their preoccupation with the Shaken Baby Syndrome hypothesis also ignored the elevation of the level of glucose in the blood and the presence of glucose in the urine of Amelia. Both these features are manifestations of an autoimmune response to antigenic stimulation as explained in the attached document.[1] In this case it was the vaccines given to Amelia a few days prior to her falling ill which initiated the process.

And here is where the problem lies.

The presence of a subdural haematoma, retinal haemorrhages and encephalopathy – swelling of the brain with ischaemic changes – doctors attributed to 'non-accidental injury' resulting from having been severely and mercilessly shaken.

The condition was given the name 'Shaken Baby Syndrome' in 1971 by a neurosurgeon Dr Guthkelch, who, unsurprisingly, could offer no other explanation for the bleeding, bruises and fractures seen in these children and incredible as it may seem, neither could the doctors in the UK who reported on Amelia a year ago. I should add there are some doctors in Australia, Canada and the USA who also have the same problem causing hundreds of innocent carers to be imprisoned. Sally Clark, Angela Canning and Trupti Patel were not the last victims of medical ignorance.

Vaccines caused the problem and Darryl Elliot was blamed. I reported the matter to the GMC and got the reply *'It would be inappropriate for the GMC to become involved in academic debate between groups of experts who hold differing opinions'*.

So it is up to the Presidents of Royal Colleges of Medicine to show some leadership and instruct their members to abandon the flat earth mainstream fabrication and adopt a rational approach. More than 40 years ago Dr Archie Kalokerinos told the world tissue scurvy was the cause of the condition they were calling Shaken Baby Syndrome.[2] Until the Medical Profession realizes that the Shaken Baby Syndrome is a fabricated diagnosis without a shred of scientific evidence they are going to continue to falsely accuse innocent people and deceive the Judiciary.

How much longer can this shameful situation continue? Parliament has an excellent example of a false conviction in the case of Darryl Elliot and should take the opportunity to rectify the situation and restore justice to people of the land and release all falsely convicted prisoners.

My intention in making a report to the GMC was to force the medical profession to realize the enormity of the distress they were inflicting on innocent people by their actions.

*Michael D Innis*
*MBBS; DTM&H; FRCPA; FRCPath*

**References**

1. Innis MD (2013) Autoimmune Tissue Scurvy Misdiagnosed as Child Abuse. Clinical Medicine Research. Vol. 2, No. 6.
2. Kalokerinos A (1974) Every Second Child. Thomas Nelson (Australia) Limited.

# Reviews

## *Birth Rites and Rights*

*Edited by Fatemeh Ebtehaj, Jonathan Herring, Martin H Johnson, Martin Richards*
*Hart 2011*
*ISBN 13: 978-1849461887*
*Publishers recommended price £45.00*

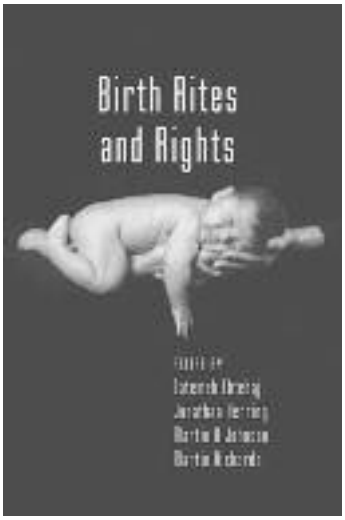
This academic book is a valuable resource for students, midwives and those with an interest birth and research. It was a fascinating and informative book to review and is written in such a manner that it is easy to locate further literature relating to the topic being discussed.

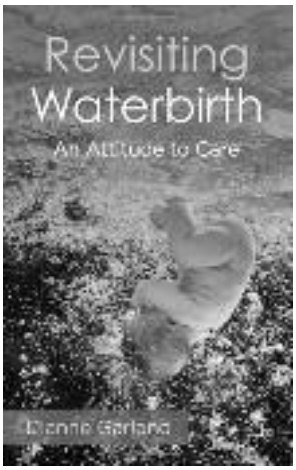
The book contains a collection of essays from the Cambridge Socio-Legal Group and is concerned with the varying circumstances, manner timing and experiences of birth. The essays come from a wide range of subjects including law, medicine, anthropology, history and sociology and examine birth from the perspective of mother, father, doctor and midwife. The book contains four parts, experiences and rites of birth, status and consequences of birth, after birth and timing of birth.

I very much enjoyed looking at the historical side of things and seeing how maternity care has changed over the decades. Each chapter is written by different authors from different fields. I did find a few chapters difficult to follow, however, for the most part I was captivated, and the scholarly thought behind each topic has given me many ideas for my final dissertation. I would highly recommend the book for students, and for those looking at research.

Although this book is undeniably aimed at academics, I believe that anyone with an interest in birth will find it informative, educational and empowering in places and upsetting in others. The changing face of midwifery is demonstrated throughout and it contains important lessons with regards to this.

***Lindsey Bowers***




## *Revisiting Waterbirth: An Attitude to Care*

*By Dianne Garland*
*Palgrave Macmillan 2010*
*ISBN 13: 978-0230273573*
*Publishers recommended price £21.99*

I have attended several of Dianne's waterbirth workshops and study days and found them excellent, informative and entertaining. I would recommend her study days to all.

I was therefore interested to read her book in the light of this and my experience of listening to the work of independent midwives specialising in waterbirth over the last 10 years. Notwithstanding a professional interest in the subject!

The book is a more in-depth, carefully worded, fully referenced version of her study day, without the entertaining anecdotes, waterbirth DVDs and activities. I think it makes an excellent baseline textbook for waterbirth, particularly in the UK health service but with relevance elsewhere.

Dianne's book is clearly written for the UK NHS and is immersed in its culture, its documents and guidelines. She provides all the quotations and references to all the documents anyone would want in persuading their sceptical unit to offer waterbirth. She provides outlines for audits and guidelines and provides detail on research across the world, pointing out some of its strengths and weaknesses. A lot of time is spent on dealing with the issues that arise in the UK in regard to waterbirth – the third stage in water, the potential (or lack of it) for water aspiration, infection control, record keeping and so on. This is very much a handbook for NHS midwives and so, whilst challenging some attitudes and practices and encouraging her readers to do the same, she writes reservedly and cautiously in contrast to other well-known waterbirth exponents. Nevertheless, there is a midwife's commitment underlying this book to provide with-woman care, to provide quality compassionate midwifery, advocating the masterly inactivity and protection of the birthing space.

I think my key concerns are where she goes along with the NHS risk-averse culture too much. On page 34 she gives an example of a care pathway for a VBAC woman.

Here she is rightly advocating for women and demonstrating how, instead of just saying 'No, you can't' to a VBAC woman's request for a waterbirth, a fully risk assessed care pathway can be set up so that a woman may have the waterbirth she chooses. Such a guideline is provided as an example. The guideline, however, is very conservative in the light of much practice: including four-hourly CTG, scans and VEs and a dry land birth rather than birth in water – although allowing women to refuse to leave and so have a waterbirth. There are these instances, then, where I can see how she is demonstrating how a sceptical medical culture can be overcome to give women choice but by the same token it may be useful to provide another example of a far more progressive and positive guideline for the same.

This is not a book for women wanting a waterbirth unless they like reading textbooks, but I think it is a very useful book for midwives, Maternity Service Liaison Committee (MSLC) representatives and other birth workers: it provides all the information you need to argue your case or provide useful backup or information for your practice. However, I would advocate a visit to Dianne's study day where, with the freedom of the spoken word, she is able to give some excellent tips on how cultures and guidelines can be and have been challenged, and provide examples of different practice worldwide which challenge our norms.

***Ruth Weston***

*Ruth Weston is a water mother of four of her five children and the owner of Aquabirths birthing pool manufacturers for maternity units, and birth pool hire for parents. She is a birth activist and member of AIMS.*

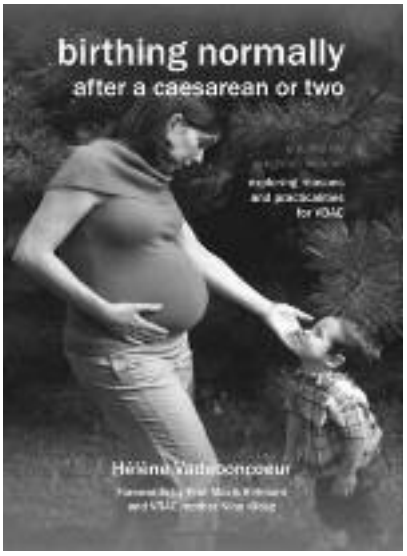
## *Birthing Normally after a Caesarean or Two*

*By Hélène Vadeboncoeur*
*Fresh Heart Publishing; British edition 2011*
*ISBN-13: 978-1906619244*
*Publisher's recommended price £30.00*

Vadeboncoeur's book covers not only all things VBAC (vaginal birth after caesarean) related, but also all things caesarean related. It also touches on postnatal depression, breastfeeding, and bonding and has something to say about most of the birth world 'gurus'.

This book holds a lot of very useful information about VBACs and their surrounding issues. So much, in fact, that I think it would have been better as a VBAC series and not a single book. I would imagine I am this book's target audience; I am interested in all things VBAC and am always on the lookout for new material. I love to read and will happily devour most things. Sadly, reading this book became a bit of a chore.

I think the main problem is that this book cares too much. It has tried to cram too many burning issues in between two covers; they could happily have sat between three or four times as many. As a result, you feel like you have to wade through a lot of material and may end up




missing a fair amount – something which I feel would have pained the author, as she is obviously very passionate about her subject matter.

Had she instead written three or four books – VBAC Stories, VBAC Studies and Statistics, VBAC Preparation and Caesarean Recovery, then it may have been an easier read.

As VBAC books go, this one is definitely worth reading as it does combine good research with some lovely birth stories and insightful advice. However, it is no way an easy read, which is a shame.

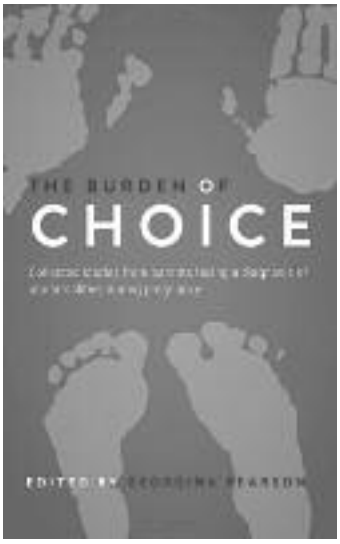
***Chloe Bayfield***

## *The Burden of Choice*

*Collected stories from parents facing a diagnosis of abnormalities during pregnancy*
*Edited by Georgina Pearson*
*Dormouse Press 2013*
*ISBN-13: 978-0956946690*
*Publisher's recommended price £12.99*

This book was compiled by a parent. She had experienced loss following diagnosis of fetal abnormality at her anomaly scan. It tells the stories of 31 families, all who faced making a choice that would affect their lives forever.

It takes the reader through the complex emotions of such a diagnosis and the choices that women and their families take based on what they have been told, their own beliefs and circumstances. It could be assumed that this book is directed solely at those facing such a diagnosis, but I would argue that health professionals involved in caring for such families will certainly benefit from reading about the raw and conflicting emotions experienced by these women and their families. The stories themselves differ in length, depth and detail, highlighting the diversity of each situation and the need to listen and not judge. This book is jargon free, which endears it to the reader and makes for 'literal' easy reading although the content can be distressing at times.



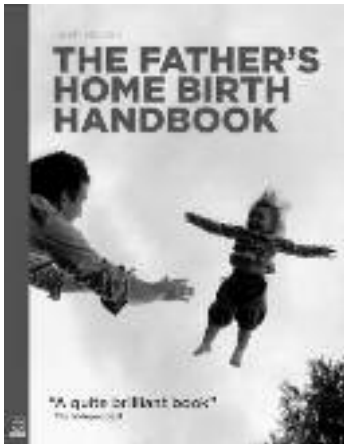

The issue of how people can differ in their response to the grief process is visited. This is very helpful for parents to understand as there can be a perception that partners/relatives are being cold or insensitive, or even dismissive of the existence of the pregnancy/baby.

Would it be suitable for the masses? I think not as it is so subject specific; having said that, I do believe that society could benefit from understanding that decision making in the face of such a diagnosis is not easily reached and that the reality held within the book shows that life hangs on a thread and nothing is certain.

The information given does guide parents to organisations that have made a real difference to the grief process; this word of mouth recommendation will be comforting to families and will direct professionals to effective support networks. Some may feel that there needs to be more of a 'professional' tone to the book, but this would only serve to diminish the very essence of its purpose. It is not all depressing reading, and some families speak of where they are now and how they got there showing there can be hope without dismissing the existence of a previous child.

So who would benefit from this book? All midwives and health professionals working in the field of obstetrics, not only for insight but to guide parents to supportive information, and of course the families themselves. I admire the strength of these families in commiting their stories to paper and sharing their innermost feelings and experiences of a situation which none of us ever wish to be in. I have definitely gained insight from reading these stories and I hope this will help me, as a bereavement midwife, to temper my practice when supporting parents.

***Sally Kelly***
*Bereavement Midwife*
*West Middlesex University Hospital*




## *The Father's Home Birth Handbook*

*By Leah Hazard*
*Pinter & Martin Ltd. 2011*
*ISBN-13: 978-1905177509*
*Publishers recommended price £8.99*

If you are a first-time homebirth dad then 'The Father's Home Birth Handbook' is the book for you! It is a book that weaves the facts of homebirth with the experience of homebirth fathers through journalistic writing and anecdotal story telling.

The factual information is presented through a question and answer style of writing. Common questions are posed – 'What about the father's role at a homebirth?' 'What about relaxation techniques such as hypnosis for childbirth?' 'What can I expect a normal homebirth to be like?' 'What are the normal stages of labour?' – and answered in an unbiased and factual style, supported with comprehensive references.

The author, Leah Hazard, has done her research, as each of the questions resonated with me (as an expectant homebirth dad) – I found the author's responses very useful and reassuring. They either confirmed what I had already learned or gave very useful pointers for further research and discussion with my partner.

The handbook is presented in seven chapters:

The first two chapters set the scene: Are you mad? A homebirth? What's involved and how to get other people on-board – family, friends and medics.

The following three chapters explore the reality of a homebirth: who to invite, who will be there, pain and pain relief, and what to expect during a normal homebirth.

The penultimate chapter addresses concerns that most people would have regarding a homebirth – what to do if there is a complication, when to transfer to hospital, how to ensure the well being of mother and baby. The 'advice' is usefully framed as 'what can I do to help?'.

The final chapter quirkily asks 'what next?' assuming that you have just successfully homebirthed your child….

In summary, this book is a well-organised FAQ for homebirth fathers – a book that can be read cover-to-cover or dipped into if specific questions arise. A recommended read.

***David Evans***

# WOW!

I just read the editorial and birth stories in the last issue of the AIMS Journal. WOW! And thank you so much for sharing. A truly amazing and inspiring collection of birth stories.

*Susan Merrick*

# Birthing choices

I have just read the birth stories in the last edition of the AIMS Journal and I wanted to tell you that it was one of the most beautiful things I have ever read. There is so much more I want to say but I can't put it into words. Thank you so much for sharing your stories.

I am particularly qualified to remark on the article by Joanna Joy as I have recently completed a study on the topic of women's reasons for, and experience of, birth with a private midwife in Western Australia. In my study I interviewed women who had birthed with a private midwife. They had very similar reasons to some of the women that Joanna surveyed. The women I interviewed were also influenced by their previous experiences, both positive and negative, and this impacted on their decisions to birth with a private midwife. They too did not want to take the chance on who would be at their birth; they wanted someone with whom they had a relationship based on mutual trust and a shared philosophy. They all were willing to do the research to get what they wanted, which ultimately was a natural, active, intervention-free pregnancy and birth where they felt safe and in control. However, the difference is that they all wanted a chosen midwife to be present for the birth. All of the women in my study did state that if the option of a private midwife was unavailable they would freebirth rather than go to hospital or choose the government funded homebirth option.

I think that this edition of AIMS really highlights and fits with the current literature which suggests that the over-medicalisation of pregnancy and birth and the obsession with 'safety and risk' rather than supporting and working with women can alienate them and induce more fear of the system.

Thank you again for providing this opportunity to read the fantastic AIMS Journal.

Keep up the good work and I look forward to reading more. If I can be of assistance I would be more than happy to help. AIMS is a fantastic resource. Thank you very much.

*Clare Davison*
*Midwifery Lecturer*
*School of Nursing and Midwifery*
*Building 21, Edith Cowan University*
*Western Australia*

# Inspiring

I would like to say many, many thanks to the AIMS member who gave away her copy of your excellent Journal 'High Risk' [AIMS Journal Vol: 23 No: 4]. A friend of a friend had been given it at a homebirth group and she passed it on to me saying how helpful she had found the information.

I was inspired by the story of Joanne, who gave birth to her twins at home, and the articles on pregnancy and obesity. It made me realise that my pregnancy and my plan to have a homebirth for my second baby was nothing like the risk that my midwives were telling me. I was not overweight, I was not ill, I was pregnant with a single, head-first baby, and I had done it all before with no real problems.

## my confidence was undermined

Clearly home was going to be the safest birth for me and for my baby, but at every appointment my confidence was undermined and the midwives would remind me that they had to tell me about the risks of birthing at home, and they did. Risk after risk, whilst every time saying that they were supporting my choice, but just making me aware of what could go wrong, and all the reasons why I might not be allowed to have my baby in the calm of my own home.

I started to worry and a friend put me in touch with a mutual friend who gave me your Journal. I was beginning to fear that something really could go wrong and that being at home was a risky thing to do. I started to worry that if something did go wrong, either my baby or I would die. The comments of the midwives were really starting to grind me down and make me doubt what I wanted and make me feel that I was selfish to want a birth that was risky for my baby.

Reading all that about birth and how it is OK even when things are not perfect helped me see that I did want what was best for my baby and that everything would be OK.

I joined some Facebook groups, I read some information on the internet and used some sample letters to write to my midwives telling them that I would be birthing my baby at home. And I did. I had a beautiful homebirth, with none of the predicted problems. The midwives arrived only just in time and they left quite soon afterwards because there was nothing for them to do.

I am glad I found the right information in time and I have now passed that Journal on to another pregnant woman. I hope it works as well for her as it did for me.

Thank you AIMS, thank you Julie for passing on the Journal and thank you Joanne for your inspiring story.

*Cheryl Cooke*

# News

## Free to leave home

*Update on the campaign to free Ágnes Geréb, 21 February 2014*

**Yes, it has finally happened! Ágnes is now free from house arrest after 3 years, 4 months and 15 days deprived of her liberty.**

It came about in the last days of February 2014, when the appeal made by Ágnes's legal team about the severity of the house arrest conditions was upheld by the Court of Appeal in Budapest. The court ordered the house arrest restrictions be removed and ruled that Ágnes could now move freely around the city of Budapest and also throughout the immediate county that the capital is situated within. She is not, however, permitted to go beyond this territory nor is she allowed to advise or consult with pregnant women whatsoever.

**court ordered the house arrest restrictions be removed**

Despite the continuance of these 'other' restrictions of movement etc., (and indeed the legal team may chose to challenge these), we on the campaign side consider this a great moment for Ágnes and her family and we would like to take this opportunity to thank each and every one of you, individual and organisation alike, for helping this day arrive. We have no doubt that all the decision makers in Hungary are fully aware of just how resolute and consistent the international support has been for Ágnes as they are aware just how much attention their actions receive abroad.

In the wider scheme of things this development is a small but significant step. Ágnes still has a 2012 two-year prison sentence set against her, which Ágnes subsequently appealed to the President of Hungary and which he has publicly stated he will review once the further cases presently taking place against her in the criminal courts are finalised. We expect these current court cases to conclude either late this year or in early 2015; during this time we must leave it to Ágnes's legal team to do their very best on her behalf. Once the courts have concluded their work and the role of the President re-emerges, the campaign team will be in contact with updates. We will also be in touch if we need specific actions from you towards influencing the President in his considerations.

But, for now, this is a special moment to savour for Ágnes even though it brings other challenges upon her and she wishes me to extend her hugs and thanks for all that you have done to make this day arrive.

With warmest regards and thanks.

*Donal Kerry*
*Justice Campaign for Ágnes Geréb*
*Budapest, Hungary*

## Hospital manslaughter?

*CPS investigating after a third maternal death*

A south London hospital could face charges of corporate manslaughter after Rosida Etwaree bled to death shortly after giving birth to twins Nabilah and Nuha by caesarean section in June 2010.

Rosida suffered a haemorrhage and died several hours after caesarean surgery. She never held either of her baby girls.

The police file on failures at Croydon University Hospital that led to Rosida's death is being examined by the Crown Prosecution Service.

Rosida was one of three women to die in the hospital's maternity department over a two-month period in 2010.

www.standard.co.uk/news/health/hospital-facing-manslaughter-charge-over-woman-who-bled-to-death-after-caesarean-9151307.html

**Ágnes enjoying her local homebirth children meeting, 5 April 2014 in Budapest.**

© Donal Kerry
Justice Campaign for Ágnes Geréb

# Publications

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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## AIMS Members Yahoo Group

Stay in touch and have more of a say in what AIMS is doing. Join the Members Yahoo Group where you will receive updates from committee meetings and notice of events, as well as being able to contribute to discussions of current issues. Join at health.groups.yahoo.com/group/aimsukmembers or email egroup@aims.org.uk

**health.groups.yahoo.com/group/aimsukmembers**