Association for Improvements in the Maternity

AIMS Journal Vol:25 No:2 2013

Remembering Women

What happens when women are not part of the decision chain?

Inquests in Ireland

Changing our thinking about birth

www.aims.org.uk

Follow us on Twitter @AIMS_online • Find us on Facebook www.facebook.com/AIMSUK

Diary

AIMS Meetings

Friday 21 June 2013 - Oxford

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

EGM

Friday 26 July 2013 - London
All members are invited to attend. email secretary@aims.org.uk for more details.

AGM

Saturday 2 November 2013 - York

Old Bailey Protest

Justice for Becky Reed
Monday 15 July 2013 to
Friday 2 August 2013

Hearing rescheduled to 2 July

A peaceful protest gathering outside the NMC offices. See www.facebook.com/JusticeForBeckyReed for details and for information on how to attend the protest or Becky's hearing in support.

University of Worcester 6th Annual Birth Conference
Midwife-Led Units: Simply the Best?
11 July 2013

Contact: 01905 855480
n.rusher@worc.ac.uk
www.worcester.ac.uk/midwifery conference

Fathers to Be
Undisturbed Birth:
The Science & The Wisdom
27 July 2013
10:00am - 4:30pm
Active Birth Centre, London

Speaker:
Dr Sarah Buckley

www.fatherstobe.org/buckley_event.htm

AIMS Talk
Birth, Babies, Breastfeeding and Beyond:
Mother Nature's Superb Design
9 August 2013 evening - Bristol

Speaker:
Dr Sarah Buckley

email talks@aims.org.uk for more info.

Birthrights
Dignity in Childbirth
16 October 2013
Royal College of Physicians, London

www.birthrights.org.uk/dignity-in-childbirth/

AIMS

Hon Chair
Beverley Lawrence Beech
5 Ann's Court, Grove Road, Surbiton, Surrey, KT6 4BE
email: chair@aims.org.uk

Hon Vice Chair
Nadine Edwards
40 Leamington Terrace, Edinburgh, EH10 4JL
email: nadine.edwards@aims.org.uk

Hon Vice Chair
Debbie Chippington Derrick
1 Carlton Close, Camberley, Surrey, GU15 1DS
email: debbie.chippingtonderrick@aims.org.uk

Hon Secretary
Vacant
email: secretary@aims.org.uk

Hon Treasurer
Stuart Lund
email: treasurer@aims.org.uk

Bookkeeper
Jackie Boden
email: treasurer@aims.org.uk

Publications Secretary
Shane Ridley
Flat 56 Charmouth Court, Fairfield Park, Lyme Regis, DT7 3DS
email: publications@aims.org.uk
Note: Orders by post or website only

Membership Secretary
Glenys Rowlands
8 Cradoc Road, Brecon, Powys, LD3 9LG
Tel: 01874 622705
email: membership@aims.org.uk

Website Maintenance
Chippington Derrick Consultants Ltd
email: webmistress@aims.org.uk

Scottish Network: Nadine Edwards
Tel: 0131 229 6259
email: nadine.edwards@aims.org.uk

Wales Network: Gill Boden
Tel: 02920 220478
email: gill.boden@aims.org.uk

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

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

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

Vol:25 No:2
ISSN 0265 5004

Journal Editor
Vicki Williams
email: editor@aims.org.uk

Editorial Assistant
Vacant

Journal Production Team
Beverley Beech
Gill Boden
Debbie Chippington Derrick
Nadine Edwards

Printed by
QP Printing, London
Tel: 020 3332 0102

©AIMS 2013

Association for Improvements in the Maternity Services. All rights reserved. Please credit AIMS Journal on all material reproduced from this issue.

Submissions to this Journal are the work of individual contributors and may not always reflect the opinions of AIMS.

Submissions to the AIMS Journal may also appear on our website www.aims.org.uk

Cover Picture:
In memory of Savita Halappanavar, who died as a result of medical misadventure in Ireland in 2012. Inquest reported on page 14.

Contents

Editorial
When Women Are Forgotten 4
Vicki Williams

Campaigning
AIMS Campaign Network 5
Debbie Chippington Derrick

March for Independent Midwifery 6
Carly Ramsay-Wilson

Articles
Improving Our Thinking 7
Elselijn Kingma

Harsh Myths, Harsher Realities 11
Jo Murphy-Lawless

Greater Manchester Marathon 13
Stuart Farmer

Irish Inquests 14
Jo Murphy-Lawless

Neonatal Resuscitation 16
David Hutchon and Amanda Burleigh

Childbirth, Nature and Culture 18
Zalka Drglin

Reports
Farce or Tragedy? 22
Donal Kerry

Readers' forum
Postpartum Aggravation 23
Alicja Piotrowska

Reviews
Where Have All the Mothers Gone 26
Kate Simpson

News
Toxic Maternity 27
Beverley Lawrence Beech

Publications 28

Editorial

When Women Are

There is no doubt that the death of Savita Halappanavar is a tragic waste of a young woman's life. There is no doubt that it is a tragic loss for her family. There is also no doubt that it is a stark reminder to those providing health care that listening to the person you are treating is the most important thing you can do, as time and time again Savita and her husband Praveen begged for help.

On page 11 Jo Murphy-Lawless talks about the dreadful state of maternity services in Ireland, and having read her experiences of the Irish Maternity Services, there is little doubt that the lack of woman-centred care and the scant regard for women as part of the decision-making process have contributed heavily to the deaths of three young mothers in Ireland over the last year. Savita's inquest is reported on page 14, and that report also touches on the deaths of two other young women, Bimbo Onanuga and Dhara Kivlehan, whose cases show, as Jo rightly points out, *'that fragmented care on top of unaccountable obstetric practice kills.'*

Women are having to fight hard to have their choices in birth respected. AIMS hears of women being refused home births, VBACs and planned sections, all within the same maternity unit. Surely this refusal to accept a woman's right to choose what happens to her body shows big gaps in both provision and standard of care, especially when her request does not differ vastly in cost or risk from care proposed to her. Does this have more to do with trying to control a woman's choices than what is either the safest or the most cost-effective care?

All is not beyond repair though. The campaigning for women's rights and for woman-centred maternity care is getting bigger and stronger, and as Debbie Chippington Derrick points out on page 5, this is only the tip of the iceberg. There is much more to do, and your support is very much appreciated. We know we are making waves when celebrity figures are passing on our tweets! Finally, with the help of some hard work and some social networking, women are claiming back their power, and rightly so, for no one else is more qualified to make the decision about what is really right for a woman than the woman herself. On page 7 Elselijn Kingma explains how this is so, and on page 18 Zalka Drglin looks at how birth can be when care meets the emotional, physical and biological needs of women.

Changing practice is hard. Sometimes very hard. However, sometimes there are ways of supporting change by enabling professionals to change practice whilst remaining within their comfort zone. The BASICS resuscitation trolley, described on page 16, is a great example of a piece of technology that will enable professionals to abandon the damaging practice of premature cord clamping but still have access to the equipment to allow them to work within their skill and knowledge base without challenge. It is a major step towards universally accepted optimal cord clamping, and whilst the guidance is currently only extending the recommended timing of cord clamping, it is moving towards the goal of waiting until the placenta has finished beating and the cord has finished pulsing before considering separating mother and child.

When mothers and babies begin to be respected by the system we will see an end to stories like that of Alicja Piotrowska (page 23) and see more care being supportive and responsive to need, rather than bullying, reactionary or dangerously neglectful. It is time to stop harassing those who are fine but declining intervention and start properly supporting those who are begging for assistance.

The work of AIMS is vital not only as a source of direct support, but also in ensuring that women are represented when policy is being made and guidelines developed. The M4M campaign and the fight to save independent midwifery are vital for the future of care that is responsive to the needs of those it cares for, that is women and their babies! To achieve all this we need your support, and so we would like to say a huge thank you to Stuart and Sam Farmer and to Debbie and Tim Chippington Derrick for raising much-needed funds for AIMS by running and cycling for sponsorship.

Vicki Williams

Support Debbie to Support AIMS

AIMS is delighted that on Sunday 9 June 2013 Debbie Chippington Derrick is going to cycle the Halvvättern (www.vatternrundan.se) in support of AIMS. Please support her in supporting us.

Debbie says: *'I am still not quite sure how a university friend of ours managed to persuade me, and my husband Tim, to join him and his wife on a cycle ride that I can't even pronounce; a cycle ride of 150km. Our friends have reminded me that it is only the Halvvättern and not the full 300 km of the full Vätternrundan. Well, that is a real comfort!'*

'You might ask if I have ever done this distance before, and the answer is No, not even in my youth! So, how far have I done in one go? Well, I have done 100km, and not too long ago. I keep thinking, "Would I have felt happy to have ridden half of it over again?" and I am not sure that I would. So, I think there are two things that I need: one is to get on with some serious training, and the other is your encouragement. Being sponsored to do this will make it difficult for me quietly to fail to complete it, which might be tempting otherwise.'

For more information and to sponsor Debbie, please visit www.aims.org.uk/?debbieCycling.htm

AIMS Campaign Network

Debbie Chippington Derrick highlights the current work of AIMS

I am not sure whether it is just where I am standing, but there seems to be a lot of talk about the quality and provision of maternity care, and particularly midwifery care.

There is the situation with independent midwives and the requirement to have insurance, which is currently unavailable, to be resolved. Information is available at www.aims.org.uk/?Campaigns/independentMidwifery.htm on the background of this situation. IMUK seem to have had a good meeting with the Health Minister Dan Poulter who has led them to believe that a solution will be found to save independent midwifery. For current details please see www.independentmidwives.org.uk/ or the Facebook pages www.facebook.com/groups/231153153595704/ and www.facebook.com/groups/fightingforims.

The results of the consultation 'Indemnity or insurance for regulated healthcare professionals' (www.gov.uk/government/consultations/protecting-patients-from-negligence), for which the deadline on comments was 17 May, should tell us whether a solution to the non-availability of insurance for independent midwifery has been found and whether the concerns that have been raised by many are going to be addressed.

The NFWI (National Federation of Women's Institutes) published a report on the state of maternity services. They carried out a survey of over 5,500 women and it makes clear what many of us already know, that many women are not getting the support that they want or need, that there is little in the way of choice, that care is fragmented and women face a 'postcode lottery' of postnatal care. See www.thewi.org.uk/campaigns/current-campaigns-and-initiatives/more-midwives/research-findings for further details.

The culmination of discussions between AIMS, NCT, ARM, IMUK and The Birth I Want has been the launch of a new campaign ***'A Midwife for Me and My Baby'*** saying: *'We want every woman to have a midwife who 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.'*

We would ask you to have a look at the campaign website www.m4m.org.uk and at the AIMS Facebook page and to follow us on Twitter for regular updates. We need as many people as possible to ***'Deliver a Baby'***. This involves sending a cut out baby with a message to your MP. Please see www.m4m.org.uk/takeActionDeliver.php. We are also asking for pledges of support from individuals and organisations, and you can also sign up for the newsletter to be kept informed of further actions and news of progress. Please do get involved yourself, and also encourage others to do so. If you use Twitter then you can post about the campaign using the hashtag #M4M.

New opportunities are opening up for the provision of midwifery services, ones that may allow the call of the M4M campaign to become a reality for increasing numbers of women. Opportunities that may mean that we will no longer be at the mercy of our local NHS Trusts for provision of continuity of midwifery care as called for by the A Midwife for Me and My Baby campaign.

Neighbourhood Midwives are ready to offer NHS midwifery care that offers true continuity of care via a social enterprise, see www.neighbourhood midwives.org.uk. By the time this Journal reaches you, the AIMS talk and workshop in Guildford on 30 May with Annie Francis (http://www.aims.org.uk/neighbourhood Midwives.htm) will have taken place. This talk will explain how this model of care will work and what the benefits are for women and for midwives. The workshop will consider how women and midwives can work together to make this care accessible to women around the country. We will provide AIMS members with a report on this via the members Yahoo group following the talk. If you are not already a member of the group you can join at health.groups.yahoo.com/group/aimsukmembers and we will bring you a report in a subsequent Journal.

One-to-One Midwifery (www.onetoonemidwives.org) has been practising in the Wirral area, but with the advent of 'Any Qualified Provider' (www.nhs.uk/choicein theNHS/Yourchoices/any-qualified-provider/Pages/aqp.aspx) One-to-One is offering women the option of self-referring. The statistics are looking good, with high home birth rates and low caesarean rates. One-to-One has just produced its annual report, which makes very encouraging reading. This is a service providing continuity of midwifery care when women have miscarriages rather than abandoning them, midwifery support at consultant and scan appointments, and care that genuinely supports women's choices rather than bullying them into the ones dictated by the system.

In Bradford and West Yorkshire the world really did change on 1 April this year. There was the change from Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs) and the new NHS constitution (as discussed in previous AIMS Journals), but it was not this that blew up in the faces of the maternity services and commissioners; it was the arrival in Bradford of a wholly midwifery-led midwifery organisation delivering one-to-one midwifery care through pregnancy, birth and beyond. One-to-One's first act in Bradford was to recruit a leading independent midwife as team leader, and a local doula and Airedale Mum as a support worker.

On 30 April they held an open day attended by well over one hundred women, doulas and midwives. A few commissioners were spotted there too. Without any advertising, the strong women's network that exists in the area has led to 24 women referring themselves in two

weeks: women voting with their feet. Organisations will be referring their clients and the commissioners will be paying the invoice.

However, as with all radical change, it has kicked up a storm of contention and confusion. Some women are fearful of referring themselves in case local hospitals treat them poorly should they need their support. Others are concerned that the women who really need the support will not be the ones who refer themselves into the care they so desperately need. The commissioners are currently opposed to the advent of One to One and have asked the company to leave the area! Needless to say One to One and the women who are referring themselves into their care are not going anywhere.

Clearly this is not ideal, but this is what happens when commissioners do not engage seriously with the needs of their service users. AIMS supporters, we need your help to ensure that the needs of women are paramount in the stormy times ahead. Women need to be clear that high standards should be expected from any provider who offers them care – whoever they choose to be their midwife. This really does seem like the time for women in different areas to consider who is best placed to provide them with midwifery services and not to continue to accept what is provided by the acute trust.

We had been concerned that the change from PCT to CCG would lead to the demise of Maternity Services Liaison Committees (MSLC) in many areas, but we are hearing encouraging news of MSLCs not only continuing to be supported, but also securing funding.

We would like to hear from you about what is happening in your area. Please email campaigns@aims.org.uk or post on the AIMS members egroup health.groups.yahoo.com/group/aimsukmembers. We would also encourage you to sign up to the AIMS Campaign Network.

Can we make this the revolution that we have been waiting for? Can we change the face of maternity care? Can we make the poor care that many of us have received be history to our daughters and granddaughters? A history that they know that we have had a hand in changing!

Debbie Chippington Derrick

March for Independent Midwifery

22 March 2013

With an early start through rush hour traffic, scampering back to the car to retrieve an extra pair of gloves for Milo (whose fascination with cold wet puddles was becoming a little wearing), a brisk car-seat swap in the drop-off point, a broken ticket machine, a stubborn toddler who would not be carried ... I started to wonder if this hassle was going to worth the reward – would anyone listen to us? The responses to my letters seemed to suggest a lack of comprehension of the problem, let alone any evidence of a solution. The wind was bitterly cold on the platform and the train was busy.

I was seated behind a group of four women sharing bad birth stories with varying amounts of regret, disappointment, fear and gore. At first I assumed they were on their way to the march, then I saw them all pick up their briefcases and get off around Luton, phones already clamped to their ears and heels clicking down the platform. Milo nursed and dozed in my arms and I was alone with my thoughts. How universal birth is. It can unite and divide us. It moves us and resonates down the generations. It is a language all parents speak and bonds the very essence of the human race together. Just like the women on the train, I too am a completely normal woman with my own bad birth story. My mother (who took time off work to support me by looking after my eldest son) has hers. We are lucky and grateful that our bad births were then followed by good ones. Hers was facilitated by a group of committed underground midwives in America and mine by the awesome independent midwives Jane Buckler and Valerie Gommon, who ensured that every moment of my pregnancy, labour and birth was mine and mine alone. I am very proud of my (slightly crazy) VBAC story, as it does not include the words 'routine', 'they wouldn't let' and 'they had to' at all.

Choice. That's what makes a good birth. That's what we marched for. Choice in screening, choice of birth place, choice of midwife and yes, choice to opt for non-NHS maternity care. We are grown adults. We can think for ourselves. It took hundreds of supporters travelling to London to get a simple meeting between IMUK and DOH's Dan Poulter, but it was joyous. It raised our profile and helped keep the light alive for all of us who will not let independent midwifery be stamped out on our watch.

Sign and circulate the petition: epetitions.direct.gov.uk/petitions/44382 and support IMUK's monthly Choose Your Midwife campaign, details at www.independentmidwives.org.uk

Carly Ramsay-Wilson

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

Improving Our Thinking

Elselijn Kingma shows us how to change maternity care by changing the way we think about it

Without doubt, our health care system should be geared up to support a wide variety of birth options, ranging from home births to maternal-choice caesareans, and should never restrict or oppose the birthing mother's free choice amongst these, except in the rarest of cases.

This conclusion is not a radical one, and what I am about to say should be neither new nor controversial as it is well-supported by both common sense and academic convention. However, somehow, in debates and decisions about birth options, it is consistently overlooked.

It is vital for the health, safety and well-being of mothers and babies that we improve public and professional debates about birth options. We should focus less time debating the evidence, and more time considering the values that play a role in discussions about birth. Those values are at present disconcertedly lop sided, paying attention almost exclusively to the harms done to babies, but not to those done to women. Health care policy should expect to cater for variety, because different decisions are right for different people, even in the face of the very same evidence on safety. When all that is understood, it becomes obvious that the ultimate and only legitimate and authoritative decision maker in birth (except in the most exceptional circumstances) is always, and only, the pregnant woman.

Focus on values, not just on facts

It is a philosophical truism that although knowing facts is important, facts alone can never determine what is the right thing to do. This is because in order to decide upon a course of action, relevant facts need to be combined with and interpreted in the light of values. For example, you could know the survival statistics and side effects of different treatment options, but those facts alone don't tell you what to do. Only once you ask how you value those different benefits, side effects and survival chances, can you identify the right decision about what course of action or treatment, if any, to embark upon.

Despite this important role for values, they often remain hidden. Take the following two examples:

'Research shows that home birth raises the risks for the baby therefore women cannot birth at home.'

'Maternal-choice caesareans are not medically necessary therefore we do not need to provide them.'

Each of these claims jumps from a statement of fact to a statement about what to do – which can only be done if there is a hidden value-claim doing interpretative work. In the first claim this may be: *'It is impermissible ever to put a baby at risk.'* In the second claim it may be: *'It is only ever permissible to provide medically necessary interventions.'*

Bringing hidden value-claims out in the open is useful for two reasons. First, because it opens up the value-claim to scrutiny. In these examples it is immediately clear that neither simple value-claim can be defended. The claim that it is never permissible to put a baby at risk is untenable. Every action has risks, and the only way not to put a baby at any risk at all is never to create one. The claim that it is only permissible to provide medically necessary interventions is false. We provide non-medically necessary interventions all the time, such as contraceptive services, and do so for good reasons.

Second, making hidden value-claims apparent improves our reasoning and arguments, and might often change our conclusions. This is not only because scrutiny often forces us to reflect on and revise our values; it is also because making value-claims explicit often reveals that we need further facts, and answers to further questions, before we can reach a conclusion. For example, in the above situation, we might decide that instead of endorsing the claim *'it is impermissible ever to put a baby at risk'*, we endorse the claim '*it is impermissible to put a baby at excessive and unjustifiable risk*'. That immediately reveals that we need more information to reach a conclusion about the permissibility of home birth: information on what are the extra risks that accrue to the baby during a home birth, their magnitude, and – most importantly – how they are to be traded off against all other risks and benefits associated with the different options.

In order to reach decent conclusions in the context of birth choices, then, we need explicitly to consider not just the facts that are relevant to our decisions and public debates, but also the values that should frame these.

Straighten out our values in the context of birth

What are the hidden value-claims involved in discussions about birth options? Take, for example, media reporting on the 2011 Place of Birth study.[1] This large and well-designed study compared outcomes for pregnancies classified as low-risk by planned place of birth in the UK. In brief, and focussing only on planned home compared with obstetric-unit births, the study found that planning a hospital rather than a home birth increases the risk of harm for all mothers, and decreases the risk of harm for first-born babies only. For second and subsequent babies, no differences in risk profiles of home and hospital birth were found.

If we take these findings at face value – and there is much to say about how exactly they should be interpreted and represented[2] – then what is striking is that nearly all news sources focussed the vast majority of their attention and emphasis on the increased risks that home poses for first babies. The message that for other babies, the options were equal, and that for mothers, hospitals universally posed a much higher risk of harm, was much less prominently displayed in the articles, and sometimes not mentioned at all.

This reporting is particularly interesting given the current state of the UK birth system where fewer than 3% of women give birth at home and there is a wide-spread perception that hospitals are both the safest and 'normal' option. In that context, surely the newsworthy message is that hospitals are in fact less safe than home (or midwifery units) for women, and only marginally safer for first-born babies, not for their younger siblings.

What does this way of reporting tell us about the hidden value-system within which research findings are reported? Crudely put, it reveals the hidden value-claim: *'Harms to babies are of far greater concern than harms to mothers.'* Or even more worryingly: *'Only harms to babies matter – harms to mothers do not.'*

That might seem an overstatement – but it is scarcely so. Only the value-claim *'Harms to babies are of far greater concern than harms to mothers'* allows one to think that increased risks to babies are worth reporting and emphasising in great detail, but that a no-difference in risk for babies in combination with an increased risk for mothers is not. Only the value-claim *'Harms to mothers are irrelevant'* allows one to think that one could ever say anything useful about birth services or a choice of place of birth on the basis of outcomes for babies alone, without needing to investigate or mention the risks to women.

As another example, take the Royal College of Obstetricians and Gynaecologists' (RCOG) official statement on the Brocklehurst study.[3] Risks for babies are reported in great detail, appropriately stratified to birth order, with mention of the absolute risks. Risks to mothers are severely underreported, and in a very unbalanced way; transfer-rates are elaborated in great detail, stratified to birth-order, whereas the only statement about interventions is: *'lower intervention rates were reported in both types of midwifery units.'* No mention of home births with respect to interventions. The RCOG too, it seems, harbours the hidden value-claim *'Harms to babies are far more important than harms to mothers.'*

This impression is confirmed by the subsequent statement: *'The RCOG has always supported appropriately selected home birth but this study has shown that first-time mothers wishing to deliver at home have an increased risk of poor outcomes for their babies thus raising questions about the right birth location for this group of women.'* Harms to women do not seem to even enter into the RCOG's reasoning process. The hidden value-claim is quite clear: *'Only outcomes to babies matter in decision-making.'*

The statement on mums having subsequent babies is even more telling: *'The case is different for mothers with no complications in their subsequent pregnancies delivering at home or in a midwifery unit. There is therefore a need to expand these facilities with appropriate midwifery staffing to improve women's choices.'* Now if harms to women were taken to matter, there would be a need to expand home birth and midwifery-led facilities to improve women's safety. It is only if baby safety is considered important, but mother safety is not, that one can arrive at the above combination of statements.

Though my analysis may sound damning, it should not make us think our newspapers and the RCOG actually endorse the idea that harms to women don't matter. The whole point of making hidden value-claims explicit is to open them up to scrutiny and reflection, which often instantly reveals them to be either unsupportable or at least unsupported by us – prompting revision.

Note that in this case we have no choice but to reject the value-claim that only harms to babies matter, but harms to mothers do not; not to do so would directly contravene equality under the law, and human rights legislation, which demands that we value all citizens and their well-being equally.

Revealing and revising the hidden value-claims in birth discussions completely changes the nature of

Revealing and revising the hidden value-claims in birth discussions completely changes the nature of the debate and the types of facts we should be taking into account: any pronouncement must not only focus on harms to babies, but also consider harms to mothers. If that is done, a completely different picture emerges from the one we have been fed so far. It becomes, for example, quite clear that the 'simple' – though revolutionary – message of the Place of Birth study is that home birth is the safest option for second to fourth-time low-risk births. Full stop. And that the 'difficult message' of this study is about safety in first-time births. In first-time births, safety pulls in different directions for the two people involved. Therefore what should be considered the overall 'safest' or 'recommended' option is a difficult question that depends on how exactly infrequent harms in babies, only some of which are very severe, are to be traded against much more frequent – but on the whole, less severe – harms to mothers.

This is quite a different message from the one the newspapers or the RCOG gave us – but one they have no choice but to endorse once they bring their hidden value-claims into the open and reflect on them.

Expect to cater for birth choice

Examining what the overall and on average safest birth option is, is one thing. Determining what options should be offered is quite another.

The basic point is very simple: people differ in their preferences. This means that very different things are good for different people. Suppose I love visual art and hate sitting still, whereas you love classical music. It seems obvious that when we both have an afternoon off, yours is best spent going to a classical concert and mine best spent going to an exhibition. It is not just

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

preferences that are relevant; circumstances are too. If both of us equally like classical music, but you have time and money whereas I do not, then, again, different choices are the right ones for us.

Differences in preferences and circumstances materially affect whether choices are good or bad for people. Something that all else being equal would be the 'best' option, may in practice be good for some people and not for others, because in practice all else is never equal.

This has important consequences for policy. Policies, particularly in medicine, should not just aim to provide what seems best all else being equal. Instead they should aim to provide what is the right thing in practice or actually the right thing for as many people as can be reasonably and feasibly accommodated. This invariably means providing for variety.

Does that point apply to birth choices? Without a doubt. Take preferences. Some people have a preference for pain relief which gives them a reason to birth in hospital that someone less keen on pain relief lacks. What holds for preferences holds for circumstances. Whether you live five minutes from hospital or on a remote island without a hospital affects how bad an emergency transport would be; whether you expect to have five more children or swear this is your last; or whether you have a large support network or are a single parent with three dependent children, very much affects just how bad a caesarean section would be for you.

Also worth emphasising is that some people – in fact a very considerable percentage of people giving birth – have histories of abuse and violation. I cannot possibly pronounce on what things may be like for them – and undoubtedly they are all different – but I have no doubt that this materially affects how good or bad different options are for them.

Data on what is the case 'on average and all else being equal' is extremely useful and important. However, to determine what is right in individual cases requires that big and legitimate additional considerations are taken into account – and these will result in different decisions for different people.

This means that our birth system should expect to accommodate these different decisions. Even if home birth is safer all round for 'low-risk' pregnancies, we should expect there to be a subgroup of people for whom hospital may be the better option, for example, because they desire narcotic or epidural pain relief, have no safe home environment, or live very far from hospital. Our health-care system has to be able to accommodate these people. Similarly, in a group of women for whom hospital birth is, on average, safer all round, we should expect there to be individuals for whom home is the better option. Again, we need to be able to accommodate them.

Because our health-care services should aim to provide the best option for as many people as reasonable, feasible and worth the cost, they should provide more options and accommodate more choices than just those that are considered safest on average and all else being equal.

This means that we do not need more data to know what birth services to provide. Indeed we need far less than we already have. What we need instead is the realisation that people differ – and with that, what choices are right for them.

Always let the mother decide

It may be obvious, medically, what the 'best' option in a particular set of circumstances is. It is quite another question who, in the end, gets to decide what happens. That, except in the most exceptional cases, should always and only be the mother.

Here is why: the reason that we are entitled to decide about medical interventions to our own bodies is that they are our bodies. For someone else to decide what happens to our bodies, and enforce that decision against our consent, is to commit a grave violation that directly contravenes our basic human rights.

It is quite clear that in the case of birth almost all attempts to impose a health-care decision on a woman against her will would involve such a violation. Forcing her to go to or stay in hospital restricts her freedom in a way that we ordinarily, and only reluctantly, reserve for criminals or the dangerously mentally ill. Practically any birth-related procedure – including something as basic as a vaginal exam or an episiotomy – effectively amounts to battery and/or indecent assault (or, in lay terms, rape) if done against the woman's consent.

Because of this, a pregnant woman's choices about her birth should always be respected. And – crucially – that does not just mean choices that are considered acceptable by those offering them. With the right to decide what we do with our body comes the right to make bad, stupid and even downright immoral decisions.

we do not need more data to know what birth services to provide

But, one may wonder, surely the mother's right to decide about who and what gets to interfere with her body is somehow limited – for example by the fetus's right to life or right not to be harmed. The simple answer is no, it is not. Suppose I need a donation of your bone-marrow, or even just a few drops of your blood, to survive. In our current legal and moral system, everyone recognises that it is within your right to deny me that life-saving bone marrow or blood, and that no one can forcibly and physically interfere with you to obtain it. Even if your decision is immoral. Even if it costs me my life. That is how much we respect bodily autonomy.

It is deeply disconcerting that there are so many people who think nothing of curtailing or overriding a pregnant

woman's right to decide what happens to her body, or of cutting her open in order to have a small chance of saving her fetus, but who would not dream of curtailing or overriding a potential bone-marrow donor's right to decide what happens to their body, or cut open a random patient in the hospital to have a large, let alone a small, chance of saving another one of their patients.

Pregnancy does not disqualify a person from citizenship. So as long as other UK citizens cannot legally be forced to donate life-saving organs or tissue after they have died, let alone during their life time, no pregnant citizen should be forced, legally or physically, to undergo interventions to save another – let alone to avert a small risk of harm to another. To treat only pregnant citizens' bodily autonomy and physical freedom as up for grabs, but not anyone else's, is a severe form of discrimination.

Having said that, let me briefly reinsert a few complications. First, maybe our legal and moral frameworks are wrong, and people's bodily autonomy should be overridden in cases where the costs are low and the benefits high. Savulescu calls this the 'duty of easy rescue'.[4] That may well be right – but if so, we should not start by restricting birth choices. The cost of interventions incurred by women in birth is relatively high compared to the benefits they confer; tens if not hundreds of interventions to save one life. By contrast, bone marrow donation, blood donation, post-mortem organ donation and perhaps even participation in medical research will save far more lives for far fewer and less severe interventions. Thus even if bodily autonomy can be overridden in the interest of another person, birthing women's choices should be respected until we have started changing our laws in those other domains.

Second, there are rare cases where pregnant women lack the ability to decide, for either physical or mental reasons. Like anywhere else in medicine, these should be handled carefully, sensitively, and with due concern for the interests of the incapacitated person.

Third, we should not confuse the right to decide with the duty to do so. Of course a pregnant woman may prefer to let someone else make her decisions for her: a trusted health-care provider, a partner, or someone else. However, she retains the right to take that decision power back at any time.

Fourth, a right to decide about medical care is not limitless; it does not mean that one can excessively over-ask the health-care system. However, it does always involve the right to refuse interventions, and, I would be inclined to think, the right to choose freely amongst the full range of treatment options that are normally, reasonably and cost-effectively provided.

The concept of over-asking is raised as an argument as to why people should not demand planned caesareans or the one-to-one care required for home births. I think that whilst in principle that is a fair argument, it does not actually hold up. Caesareans are not vastly more expensive than other forms of birth care, and home births are actually cheaper,[1, 5] so it becomes difficult to construe either as a case of over-asking.

Conclusion

It is vital that we should examine the hidden value-claims that play a role in our arguments. These value-claims are at present dangerously lopsided, valuing babies almost at the complete expense of their mothers. They need to be replaced by a value-system in which harms to mothers and babies are both given due consideration. In addition, health-care services should expect to provide a wide range of options, because people differ in preferences and circumstances, meaning that different options are right for individuals, even in the face of unified average safety data. The final decision on birth options is the mother's, and cannot be opposed except in the most exceptional circumstances.

What, in practice, does this mean for our birth system? It seems to me, first, that the UK should offer a range of birth options ranging all the way from obstetrician-led birth, including maternal-choice planned caesareans and pain relief – where costs allows – to midwifery-led, in hospital, out of hospital and home birth care, with a choice of who provides that care and with good obstetric back up and swift, integrated referral systems in place. Why? Because each of these options offers different risk, safety and benefit profiles, which are reasonable choices for at least a substantial subgroup of women. Women should – with only few exceptions – be entitled to choose freely between these services, even when their choice seems unreasonable or immoral to service providers.

Of course birth providers are free to express concerns and lay out reasons when they fear a dangerous choice is being made. In fact, they probably should do so. But they cannot coerce, pressure, emotionally blackmail or misinform. Nor can they withhold basic forms of care that range within the normal. It serves everyone always to remember that each of us is fallible – not just pregnant mothers.

Is this radical? It really ought not to be, but it is by the standards and tone of current debates and practices. Those practices, and the value-systems and assumptions that underlie them, need urgent, critical and humble reflection and re-examination.

Elselijn Kingma
Socrates Professor in Philosophy and Technology
University of Eindhoven
Teaching and Research Associate
University of Cambridge

References

1. Brocklehurst, P (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. BMJ 2011; 343 doi: dx.doi.org/10.1136/bmj.d7400
2. AIMS (2012) Birth Place Study vindicates midwife units and home birth. www.aims.org.uk/pressReleases/birthplaceInEngland.htm
3. RCOG (2011) Statement on the results of the NPEU Birthplace study. www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-results-npeu-birthplace-study
4. Savulescu, J (2007) Future People, Involuntary Medical Treatment in Pregnancy and the Duty of Easy Rescue. Utilitas. Volume 19, Issue 01.
5. National Collaborating Centre for Women's and Children's Health (2011) Caesarean Section (2nd Edition). London: Royal College of Obstetricians and Gynaecologists.

Harsh Myths, Harsher

On 28 June, 2011, there was a discussion about our maternity services on Ireland's premier radio news programme, Morning Ireland, during which Professor Michael Turner, former Master of the Coombe Hospital and currently National Clinical Lead in Obstetrics and Gynaecology, stated how excellent and how safe those services are, adding that Ireland has one of the lowest rates internationally of maternal and perinatal mortality.

These claims about the maternity services and, in particular, the canard about our having one of the lowest rates or even the lowest rate of maternal mortality in the world have been repeated so frequently and uncritically in so many different settings by politicians, medics, health service administrators, policy analysts and research midwives as to become an accepted 'fact'. For decades, Irish obstetricians had no compunction in dining out on this 'fact' as proof that their rigid control of maternity care worked best, despite the 'fact' being based on local and national data sets that were woefully incomplete. This same 'fact' even found its way into the 2008 UNICEF international report on maternal mortality.

statistics should carry a 'health warning'

However, there has been some recent disquiet and in 2007, Colm O'Herlihy, a professor of obstetrics based in the National Maternity Hospital, Holles Street, published a piece stating that our statistics should carry a 'health warning' because of 'significant under-reporting' attributable to the flawed data collection process.[1] In 2008, a maternal death enquiry team, the Maternal Death Enquiry (MDE), was finally set in place to run as part of the triennial UK national confidential enquiry. A first report on Irish data was issued in August 2012. That report states that data collection continues to be incomplete due to the following factors:

- an 'inconsistent' approach to data classification on the part of coroners and the lack of a 'national approach to the notification of deaths';
- the need for a question on pregnancy status at time of death to be included on the coroner's certificate;[1]
- 'uncertainty' about who has responsibility in community health services to report to the MDE;
- incomplete engagement on the part of some hospitals, mainly general hospitals because of concerns on the part of the latter about 'data protection, potential litigation, and anticipated review of cases by other agencies outside the MDE process.'[2]

In relation to that last, the report's authors add that 'in some hospitals' it was 'occasionally difficult' to access data.[2]

To the above can be added:

- the absence of nationally observed protocols on serious maternal morbidity;
- the absence of a law requiring all possible maternal deaths to be subject to a coroner's inquest.

Given these problems, the composite figures on maternal deaths from 2009 to 2011 can be viewed at best as preliminary. The twenty-five maternal deaths the MDE has pinpointed over that three-year period give an approximate rate of eight per 100,000 maternities. This compares with 11.9 per 100,000 maternities in the UK for the period 2006-2009 and, on another scale of comparison, eight per 100,000 live births in France, seven per 100,000 live births in Norway and five per 100,000 live births in Sweden.[2] Thus, at best, our figures for maternal deaths are only average compared with near neighbours in Europe.

The MDE is funded by the Health Services Executive (HSE), the operational body for all health services in Ireland, on behalf of the government Department of Health and Children. It is an official body. Notwithstanding this, incessantly in the past six weeks, we have heard repeated in print, on the floor of the Irish Parliament, the Dáil, and on the airwaves by the current Minister for Health, by other politicians, and by administrators, journalists and commentators either that *'we have one of the lowest rates of maternal mortality in the world'* or that *'we are one of the safest countries in the world where women can give birth'*.

The renewed energy given to circulating this fiction is bound up with the tragic death of Savita Halappanavar on 28 October in Galway University Hospital (GUH), news of which broke on 14 November. Ms Halappanavar was seventeen weeks pregnant when she was admitted to GUH suffering back pain on 21 October. She was told that her pregnancy was not viable and that she was miscarrying. News of her death one week after her admission, from suspected E.coli ESBL and septicaemia, became an international scandal: she and her husband had both asked for this unviable pregnancy to be brought to a conclusion when the miscarriage process, with accompanying pain and physical distress, began to stretch beyond a day, rather than the several hours initially said to be likely by attending clinicians; this request was not granted.[3]

Unknowingly, this beautiful Hindu woman, a dentist (and therefore with a medical training), reignited the terrible political controversy over the 1992 X case. In that year, a 14 year-old girl became pregnant as a consequence of rape and was at first prevented by the then Attorney General from leaving the country with her parents to travel to the UK for a termination, under the so-called pro-life amendment of 1983 which gave equal status to the life of the 'unborn child'.[4] A subsequent Supreme Court ruling permitted X to travel on the grounds that her threatened suicide posed a real and substantial threat to her life, as distinct from her health, and under the circumstances of a substantial threat to a woman's life, a medical termination was lawful. The Supreme Court judgment stated that the government must legislate for these circumstances. No government has done so since 1992. In 2011 the European Court of Human Rights, in the case A, B, and C v Ireland, ruled that the Irish government had violated C's human rights in denying her legal access to a termination in Ireland at a time when she was dealing with a diagnosis of cancer. Legislation to bring the government in line with the European Court ruling had not been forthcoming up to the time Ms Halappanavar died, and the findings of an expert group, convened by the current government on this very topic, were delivered to the Minister for Health only days before news of her death was released.

complex politics surrounding abortion

The complex politics surrounding abortion over these twenty years have seen the virtual collapse of the authority of the Irish Catholic hierarchy but a rise internationally of anti-abortion lobbying, much of it associated with and funded by far right groups based in the United States.

In the immediate days after Ms Halappanavar's tragic death, a number of prominent Irish obstetricians, including the current and former Masters of the National Maternity Hospital, stepped forward to state that doctors as a whole needed clarity on the legal position about X. They wanted the government to formally codify the contexts of obstetric clinical judgements made to save a woman's life which necessarily entail a medical termination.[5, 6]

As upsetting as these convoluted circumstances are, the shadow of the X case is but one dimension of the troubling events surrounding the maternity services in the same period as Ms Halappanavar's tragic death. Six other maternal deaths in three other units have been publicly reported this year, three of these deaths occurring in the five weeks before and after the death in Galway.

An inquest in November 2012 on one of the deaths returned an open verdict on the woman who was found off the rocks of Howth Head in March 2012, after being missing since the previous day. She was 38 weeks pregnant with twins and had a history of depression, including depression in her two previous pregnancies. The Master of the Rotunda Hospital, where she had been attending and where she had seen a psychiatrist, told the inquest that their practice for almost two decades has been to hold notes on a patient's mental health separate from antenatal clinical notes for reasons of 'patient confidentiality'. In light of Professor Gwyneth Lewis's work on deaths from psychiatric causes in successive UK national confidential enquiries dating back to 1997, this practice seems bizarre.

The circumstances of each of the maternal deaths this year are different and perhaps very different from the circumstances of Savita Halappanavar's death about which we still know so little. Yet all these deaths have meant unbearable suffering for the women and for their families. At least fourteen children have been left without mothers at year's end. And, because of the aforementioned problems with data recording and data disclosure, even these seven deaths may not be the full picture.

Professor Susan Bewley, who has carried out research on a doubling of the rate of maternal mortality in London's hospitals since 2005, notes that although absolute numbers are still small, maternal deaths are nonetheless *'a sensitive measure'* of the quality of maternity services.[7] Pregnancies may well be more complex and women potentially more unwell, but Bewley argues convincingly that maternity services that are understaffed and under pressure may be less able to respond with quality care for women who are ill.[7]

And this is the rub in Ireland. All the myth-making about excellent maternity care and outstandingly low rates of mortality cannot obviate the concrete impact of massive cuts. These cuts have torn services apart since the economic collapse, services that were already poorly thought-through, frequently working outside current evidence, riven with obstetric authoritarianism, and significantly understaffed before that collapse took place.[8] What Bewley says about London services, that staff are *'working harder and harder to stand still'*[8] is also the state of play here, to the clear detriment of women.

An inquest into Savita Halappanavar's death in Galway will be held later in 2013. There are currently two other official inquiries into her death, neither of which has the support of her husband, Praveen, who has stated he has no confidence in GUH nor in the Irish health authorities to establish the truth of events.

We have a very poor history in respect of other inquiries about serious failures and worse in relation to women's reproductive health: the symphysiotomy scandal affecting hundreds of women over four decades in the mid-twentieth century, the hepatitis C scandal of the 1970s through the early 1990s where women received contaminated blood, the Neary scandal, where over 25 years, scores of women had unnecessary emergency hysterectomies, the scans misdiagnosis scandal of 2010, to name but a few. Almost four years after the death of Garda Tania McCabe from haemorrhage and DIC after

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

the birth (and death of one) of her twins by caesarean section in 2007 in Our Lady of Lourdes Hospital Drogheda, and following on a successful civil case against the HSE and the hospital in 2011, both bodies apologised to her widower.

What can an apology possibly mean in such circumstances when people have had to fight so hard to have institutional and official efforts to deny responsibility unmasked and overturned? We want no more worthless, fatuous apologies.

I have written before of how urgently we need the ethic of truth-telling in these circumstances and about our maternity services overall in these troubled times.[9] We can hope perhaps for 2013 that more and more midwives will understand the integral logic of this and will speak out on behalf of the women for whom they care. It is that practice of truth-telling that defeats the corrupting effects of silence and the consequences of practices so chaotic and unacceptable as to cost women their lives.

Jo Murphy-Lawless
School of Nursing and Midwifery, Trinity College Dublin

References

1. Murphy, C. and O'Herlihy, C. (2007) Maternal Mortality Statistics in Ireland: Should They Carry a Health Warning? Irish Medical Journal. 2007 Sep, 100 (8):574.
2. Maternal Death Enquiry Ireland (2012) Confidential Maternal Death Enquiry in Ireland, Report for Triennium 2009-2011, Cork: MDE.
3. Holland, K and Cullen, P (2012) Woman 'denied a termination' dies in hospital. Irish Times, 14 November 2012 www.irishtimes.com/news/woman-denied-a-termination-dies-in-hospital-1.551412
4. Murphy-Lawless, J (1993) Fertility, Bodies and Politics: the Irish Case. Reproductive Health Matters, Number 2, November 1993, pp. 53-64.
5. O'Regan, Eilish (2012) 'We won't let women die', says professor. Irish Independent, 15 November 2012. www.independent.ie/national-news/we-wont-let-women-die-says-professor-3294626.html
6. Wayman, Sheila (2012) 'I do not want to wait until she's dying before I intervene' Irish Times, 27 November 2012. www.irishtimes.com/newspaper/health/2012/1127/1224327139941.html
7. Laurance, Jeremy (2012) Doubling of maternal death rate blamed on shortage of midwives. London Independent, 30 April 2012. www.independent.co.uk/life-style/health-and-families/health-news/doubling-of-maternal-death-rate-blamed-on-shortage-of-midwives-7689172.html
8. Murphy-Lawless, J (2011) 'Ceiling Caves In': the current state of maternity services in Ireland. MIDIRS International Midwifery Digest, December, 2011, Vol. 21, number 4, pp. 446-451.
9. Murphy-Lawless, J (2011) Childbirth Adrift in Ireland, AIMS Journal, 23 (3), 2011, pp. 22-24.

Greater Manchester Marathon 2013

28 April 2013

In September 2012 I was drawn to an advert in a running magazine, for the Greater Manchester Marathon. After a short investigation of the website, I had suddenly committed myself to six months of tough training. I'd only ever run a half marathon before and quickly realised that this was a very serious challenge. I was keen however to set myself a target of sub 4 hours, which is regarded as amateur runners' nirvana. By the time I joined the other 7000 entrants at the starting line, I had completed over 560 miles of training in wind, rain, snow and more snow.

The day itself was perfect, dry, not too hot with little wind. The course started and finished at Manchester United's Old Trafford ground, taking us for 26.2 miles around south Manchester, through Sale, Timperley, Altrincham, Carrington and Flixton. My plan was not to set off too quickly and to pace myself for the first eight miles, put in some hard work up to 20 miles and then hope I had something left for the final six.

The crowds of people all along the course were fantastic, they seemed to carry us mile after mile, past Salford Quays, Media City and Brooklands. Before too long I realized I was half way and still feeling good, my confidence started to soar. I pushed on harder as the course thinned out as the groups of runners got further apart. At 18 miles I was starting to wonder if I had used up too much energy too quickly but got myself to 22 without too much bother.

Suddenly around the next corner everything started to hurt, by 23 miles my body was starting to tell me it didn't want to go on. But what I noticed was that whilst the crowds had cheered us all the way round, in the final three miles it was the runners pushing each other to the line through gritted teeth. A great shared experience, despite the pain. When I finally crossed the line, so many emotions and feelings passed through me, relief, pride, excitement, a wave of tears and cramp. My wife tells me this is a bit like child birth, much like my statement, 'I'm not doing that again.' I'll take her word for it. I was even more thrilled to learn my official time was 3:50:56, which was a huge surprise, given my struggle in the final few miles. But a just reward for all that hard training, early nights and good diet.

I'm delighted to have also raised £217 for AIMS over the last month or so, an important organization very close to my wife Sam's heart, and now a week later I'm starting to wonder if I do fancy giving it another go!

Stuart Farmer

Irish Inquests

Jo Murphy-Lawless looks at the inquest into Savita Halappanavar's death and its aftermath

The full inquest on the death of Savita Halappanavar opened on 8 April 2013 and concluded on 17 April, with the jury returning a unanimous verdict of medical misadventure. The jury also endorsed nine recommendations for fundamental change. Two of the recommendations alone reveal the utter clinical impoverishment of Irish maternity services:

- that protocols on the management of sepsis along with 'proper training and guidelines for all medical and nursing personnel' should be instituted;
- that a protocol for sepsis be written for each individual hospital by its microbiology department and be applied nationally.[1]

University Hospital Galway is a third level hospital meant to provide comprehensive acute services for the western region of Ireland. It is beyond the bounds of understanding that a third level hospital had insufficiently clear protocols in place for the management of sepsis, including training, that were reliable, evidence-based, and above all, with all staff up to date on their use. It is beyond belief that the many clinicians involved in Savita's care from Sunday 21 October 2012 to Wednesday 24 October were so hapless as to be unable to try to discern warning signs in her condition during that period and take swift action; or even to ask themselves what substantive risks there might be for a woman in the process of an inevitable miscarriage and proactively look for warning signs.

Why, when this woman's condition did point to genuine risks, was she not strictly monitored?

We know that obstetric clinicians, driven by interventionist imperatives, are quick enough to imagine the worst of outcomes for pregnant and labouring women in ordinary circumstances and react accordingly, very often to the detriment of women's well-being. Why, when this woman's condition did point to genuine risks, was she not strictly monitored? The inquest revealed that the confusion arising from the 1992 constitutional ruling on the X case, that a woman whose life is at risk can be given a termination, formed only one strand, if a significant one, in the appalling lapses of care Savita endured.

It is even more distressing to read a recommendation that calls for 'proper and effective communication between staff on-call and a team coming on duty'.[1] Surely this is what comprises basic clinical care that people expect as a matter of course when entering hospital, that clinicians communicate effectively with one another?

The inquest explored a terrible catalogue of errors: the blood sample taken on the Sunday evening which was never followed up or noted again, which would have shown an elevated white blood cell count; an examination by the obstetric consultant on Monday morning, over eight hours after the membranes had ruptured fully, showing 'no infection', but a full blood screen and c reactive protein test were not ordered to confirm that; instead, a clinical decision to 'await events' was taken; readings showing an elevated pulse which were taken on Tuesday evening by an alert student midwife were not picked up by senior clinical staff; then a large gap of time when vital signs were not taken; Savita's shaking with cold in the early hours of Wednesday morning was attributed to a cold room, with an extra blanket brought in for her, while paracetamol was given for her raised temperature, her pulse and blood pressure not recorded, and no alarm bells sounded; the note made by a junior doctor about a foul-smelling discharge from a vaginal swab taken some hours later at 6.30am, which was not picked up by the consultant obstetrician at 8.30am; bloods taken at 7am that Wednesday morning did not reach the laboratory until three hours later.[2] In his summing up, the Galway Coroner, Dr Ciarán MacLoughlin, said that by 1pm, when the consultant obstetrician was contacted again, Savita 'was in peril of her life'.[3]

A microbiologist called in as an expert witness by the Coroner noted that on the Sunday she was admitted, Savita was not given a vaginal examination nor was she checked for leaking amniotic fluid. This consultant also took issue with the type of antibiotics finally prescribed on the Wednesday, the wrong drug for the extent of the sepsis and the E. Coli ESBL, and the lack of 'prompt attention' to deliver the fetus.[4]

What was perhaps even more unbearable to hear was how Savita, in tears, was subjected to an ultrasound on several occasions to determine if there was still a fetal heartbeat. This surveillance related to a possible decision about a medical termination by Dr Katherine Astbury, the consultant obstetrician in charge of Savita's case, in accordance with that consultant's interpretation of what constituted a risk to the life of the woman.

In February 2013, there was a series of hearings before the Oireachtas Health Committee, a joint parliamentary committee, in which obstetric consultants from the Dublin maternity hospitals stated that six terminations had taken place in the Rotunda Hospital and three in the

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

National Maternity Hospital in 2012. They were taking their lead from guidelines published by the Irish Institute of Obstetricians and Gynaecologists which is all consultants have to rely on, given the current legislative vacuum. They estimated that the numbers of terminations nationally to save women's lives 'could be as low as 10 or as high as 30' in any given year.[5] Is it really conceivable that these same obstetricians wait on all similar occasions to perform a medical termination when there is no fetal heartbeat, until severe chorioamnionitis has set in, until the delay most certainly puts a woman's life in the balance?

If that passes for good-quality clinical care, women in Ireland should feel a sense of dread in having to enter a maternity unit at all

The barrister for the hospital and the Health Services Executive maintained an aggressive presence throughout the inquest. In respect of the nine hours between Tuesday night and Wednesday morning when there was no regular recording of vital signs, this barrister argued that it would be incorrect to say that no vital signs had been taken as Savita's temperature had been taken on two occasions. If that passes for good-quality clinical care, women in Ireland should feel a sense of dread in having to enter a maternity unit at all.

In the wake of the inquest, those who carry the principal responsibility for the poor quality of our maternity services, namely the community of consultant obstetricians who stand at the apex of this system, continue to dodge that responsibility. They appear to prefer splitting hairs and defending their own positions with their considerable egos. Peter Boylan, former Master of the National Maternity Hospital, who was an expert witness at the inquest at the Coroner's request, tried to argue that given the current legal vacuum, Savita was not ill enough and therefore not enough at risk of losing her life on Monday or Tuesday to justify a termination, whereas by Wednesday morning she was, but it was too late to carry it out in order to save her. His focus was not the clinical care and he effectively exonerated the consultant obstetrician in charge of Savita's case about that dimension. Boylan is determined to get legislation in place on the X case so that clinicians will have some legal safety in the decisions they must take on medical terminations. Yet he gave no indication at the Oireachtas hearings in February that women were literally at death's door before he intervened in the National Maternity Hospital. On the other hand, in a recent letter to the Irish Times, some of his obstetric colleagues including two consultants from Galway, one the professor emeritus of University Hospital Galway, objected to Boylan's position about termination. They argued variously and confusingly, that maternal mortality is on the rise in developed countries, that this was one of the worst cases of sepsis ever seen, that E. Coli ESBL is extraordinarily virulent, and that hospitals must reflect on the lessons from the inquest.[6]

The battle lines now dividing Irish obstetricians on the need for legislation for the X case do not get us to the heart of the matter. Despite their speeches and positions about how they care for women, what neither side is doing is stepping forward to say that our services are in need of urgent reform from the top down, starting with the consultants themselves. Many of the 125 consultants in Ireland are very wealthy indeed as a result of their generously paid public contracts which historically have left considerable scope for a lucrative private practice. Yet it is as if the standards of care have little or nothing to do with them, even though it is their interests and their decision-making which most determine our services. This is the same professional group which has consistently blocked any wide-ranging initiative to establish midwifery-led care.

At the conclusion of the inquest, Praveen Halappanavar, Savita's husband said: *'She was just left there to die. We were always kept in the dark…It's horrendous and barbaric and inhuman the way Savita was treated in that hospital.'*[7]

We are now in the midst of the inquest for Bimbo Onanuga, an impoverished Nigerian woman who died in the Rotunda in 2010 from a ruptured uterus leading to DIC and cardiac arrest, after she had come into the hospital for treatment for a late intrauterine fetal death. An inquest has been urgently sought about Dhara Kivlehan, an Indian woman married to an Irish man, who developed pre-eclampsia and died from HELLP syndrome after a caesarean in Sligo General Hospital in 2010.

What may be the lessons from the deaths of these three young, healthy women? That fragmented care on top of unaccountable obstetric practice kills. Our overriding problem continues to be how to make the Irish obstetric community truly accountable for its work.

Jo Murphy-Lawless

References

1. Irish Times (2013) Recommendations. Irish Times Saturday, 20 April, 2013.
2. Sheehan, M. (2013) Shortcomings in care of Savita have ramifications for all State hospitals: Inquest shows litany of mistakes caused fatal infection to be missed. Irish Independent, 14 April 2013.
3. Holland, Kitty (2013) Death by Medical Misadventure. Irish Times, 20 April 2013.
4. Cullen, Paul (2013) The systems, not individuals, to blame? Irish Times, 19 April 2013.
5. Kennedy, Geraldine (2013) Valuable debate complete with medical facts, figures. Irish Times, 19 February 2013.
6. Monaghan, John et al (2013) Letter, Irish Times, 30 April 2013.
7. Irish Daily Mail (2013) The Inquest's Key Quotes, Irish Daily Mail, 20 April 2013.

Neonatal Resuscitation

David Hutchon and Amanda Burleigh look at breathing support and optimal clamping

Have you ever thought that your baby may require resuscitation? Perhaps you have tried to avoid such thoughts, knowing the distress which might be felt by you and your partner, when, just at the moment your baby is born, it has to be moved over to the resuscitaire to help it start breathing. The distress is only slightly reduced by the thought that everything is being done to help your baby change from breathing through the placenta to breathing in air.

Usually the resuscitation is carried out at the opposite corner of the room and surrounded by doctors, so you may not even know that your baby is recovering. When your baby does begin to cry, the sound of its cry will never be sweeter. Fortunately this is the usual outcome and many babies taken over to the resuscitaire need nothing more than support to stay warm and start breathing on their own.

So is it always really necessary to take the baby away from its mother? 'Better safe than sorry' is the usual motto. By taking the baby over to the resuscitaire 'just in case', any delay in accessing equipment is avoided. This has been the tradition and rationale in hospital births for the last 50 years but things are changing. The umbilical cord is only about 30cm and third stage guidelines used to dictate early clamping and cutting of the cord, readily allowing the baby to be moved away from its mother, but guidelines to prevent bleeding after the baby is born now recommend delayed cord clamping.[1, 2]

Increasing numbers of parents are becoming aware of the importance of delaying clamping, and the evidence shows that the baby benefits from avoiding premature clamping and cutting of the umbilical cord. Parents are entitled, in their birth plan, to ask for delayed clamping which follows the International Liaison Committee on Resuscitation (ILCOR) produced in 2010 and drawn up for the benefit of the baby.[3] Despite an increased demand for delaying cord clamping, due to the perceived need for resuscitation, in 17% of all hospital births parents are being denied their request and told delayed clamping is impossible if the baby requires any form of resuscitation.

In an audit last year at a large teaching hospital, 75% of all babies had the cord cut within one minute of birth. An audit of women who had requested delayed cord clamping showed that only 8% got their wishes regardless of their baby needing resuscitation or not. As the baby is delivered the intervention of cord clamping is likely to be low down in the parents' thoughts and once the cord is clamped it is irreversible. Reinforcing the request for delayed cord clamping during labour and during the second stage may help the midwife or doctor keep the request in their mind.

The Day-by-Day Pregnancy Book by Dr Maggie Blott explains that the umbilical cord will normally be clamped two to three minutes after birth, explaining that evidence shows that this boosts the baby's oxygen and blood volume. Professor Lesley Regan, in her book Your Pregnancy Week by Week, explains how the baby changes from placental respiration to lung respiration at birth involving the circulatory changes in the heart and ending with closure of the placental circulation. What to Expect When You're Expecting by Heidi Murkoff also describes the few minutes that are allowed before the cord is clamped and cut. The expectation therefore, for those women who read these popular books, is that delayed cord clamping is just normal practice.

Mums are often upset by this unwanted and unhelpful intervention:

'I would be quite upset if my newborn baby was denied delayed cord clamping. However, if it was denied due to emergency reasons I would try and understand, but any other reason would make me feel frustrated. As I am so aware of delayed clamping now, I feel that it should be common practice. It carries so many benefits to children and I did not think it posed any risks whatsoever.'

Tatjana Grozenoka May 2011

'I was considering delayed cord clamping because of the health benefits it has for the newborn baby. It was not able to be given due to the quick delivery of my child. I didn't meet any resistance as I did not have time for a discussion about it. If there was a mini resuscitaire available it would put my mind at ease in case of problems, I think it would be a fantastic idea to have one available. I think the demand for delayed cord clamping will increase with more public knowledge of the benefits. If they said no I would have wanted to know the reasons why and would have been angry as it is my choice as a mother.'

Zoe Ambrose May 2011

'The reason I wanted delayed cord clamping was because I had researched it myself and had read about all the positive effects it would have on my baby. In my mind there was no reason for the midwives at my labour to cut the cord immediately so that's why we had chosen to have delayed cord clamping. If there was a mini resuscitaire trolley with oxygen and suction available during my delivery I think the midwives would have delayed cord clamping without endangering my baby. But since there wasn't one there, they did not delay cord clamping. I definitely think if they had a bedside resuscitaire in the delivery rooms in the future the midwives would not rush to cut the cord even if there is a slight complication. I must say I was disappointed when they did not do it because the midwives' priorities were to get my baby out and when they did he was safe and healthy and so was I. So I didn't understand why they had to cut the cord in such a rush. Sadly I did not ask anyone why.'

Ambia Begum May 2011

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

Resuscitation without dividing the umbilical cord

David Hutchon spent a year working in a remote area of New Zealand where it was not unusual for the midwives to be single handed. If the baby failed to start breathing, the midwife was already prepared. With the newborn baby lying on the bed by its mother's legs, tubing with suction and oxygen had already been led from the wall mounted resuscitaire to the delivery bed and was ready to be used to initiate resuscitation. The midwife did not need to leave the mother and was able to watch for any worrying bleeding. The baby was wrapped in a warm towel and kept close to its mum (with dad usually also by the side of the delivery table) and the umbilical cord left intact so that for several minutes the baby benefited from the oxygen from the placenta. Just as in hospital births in New Zealand, there was rarely any need for anything to be done other than stabilisation and warmth. An important difference, however, was that the mother and baby were never separated.

It has been traditional for hundreds, indeed thousands, of years to separate the baby from the placenta at some stage rather than carry the baby around with the placenta for several days. However, the time that the baby has been left with the placenta attached by the cord has steadily decreased, particularly with the advent of oxytocic drugs approximately 50 years ago, so that nowadays early cord clamping and cutting (within 20 seconds of birth) is common, especially in hospital births.

By depriving the baby of its additional oxygen, this may make the need for resuscitation more likely. This was recognised in 1954 when Geoffrey Dawes showed the evidence from his work in lambs: *'We learnt that if the cord is ligated before respirations begin, profound asphyxia results.'*[4] If there is a large loss of blood these babies will be in poor condition and need resuscitation and sometimes blood or fluid transfusion. Loss of a large placental transfusion typically occurs when there has been fetal distress due to cord compression. Allowing the baby to receive the placental transfusion is just as important as getting resuscitation initiated. However, both are possible at the same time as explained above.

Resuscitation with the baby between the legs of the mother is a well-recognised way of ensuring the baby gets an adequate placental transfusion and is not hypovolaemic (short of blood). An alternative approach, and one which is more acceptable to many practising in a high-tech setting, uses the new LifeStart trolley. It is less expensive than a traditional resuscitation trolley, is fully mobile and allows resuscitation with the cord intact in all sorts of births. The resuscitation equipment means that the neonatologist is not compromised by any lack of equipment and the baby is not compromised by the loss of oxygen or placental transfusion.

The trolley and the project to encourage bedside resuscitation to be made available to all babies, facilitating optimal cord clamping even for those babies who are or may be compromised, is called BASICS (Bedside Assessment Stabilisation Immediate Cardiorespiratory Support).

This trolley also enables parents to have their baby close and visible to them, and for their baby to benefit from the continued nurturing care that the placenta has bestowed on their baby for the duration of the pregnancy without any real or perceived technical issues for attending medical staff.

Clinical evaluation of the equipment is underway. This equipment is available to be ordered by your maternity unit now, so there is no reason why bedside resuscitation facilities cannot be provided to every mother and baby, and why physiological cord clamping, with all its advantages, cannot be offered to all babies, but particularly to those who are already compromised or vulnerable who would stand to benefit most from continued placental oxygenation.

If you are on your local MSLC, Labour Ward Forum or other maternity care strategic or campaign group then this may be a great way of helping clinicians and mothers reach a solution so that mums and babies are not separated and clinicians have all the equipment they are familiar with using.

Clinical trials using the trolley are also underway in helping very pre-term babies transfer from placental to lung breathing, and for these babies the likelihood is that delayed clamping will be very beneficial.

David J R Hutchon
Retired consultant obstetrician
Amanda Burleigh
Midwife

References.

1. WHO (2006) Recommendations for the Prevention of Postpartum Haemorrhage. October 2006. p15
2. ICM (2006) International Confederation of Midwives and International Federation of Gynaecology and Obstetrics, Prevention and Treatment of Post-partum Haemorrhage - New Advances for Low Resource Settings: Joint Statement, ICM: The Hague; London: FIGO.
3. ILCOR (2010) Wyllie J, Perlman 1M ,Kattwinkel J, Atkins D1, Chameides 1, Goldsmith JP et al. On behalf of the Neonatal Resuscitation Chapter Collaborators Neonatal Resuscitation. 2010. International consensus on cardiopulmonary resuscitation and emergency cardiovascular care science with treatment recommendations.
4. Murray M (2007) Antepartal and Intrapartal Fetal Monitoring. Springer Publishing.

BASICS trolley (Bedside Assessment Stabilisation Immediate Cardiorespiratory Support)

Childbirth, Nature and

One of the greatest gifts of my childhood was to be in direct contact with animals. My palms still feel the memory of wonder when feeling kittens move under the black fur of my kitty, while ample and searching for a place to have her litter.

I am grateful that she was allowed to have her four kittens in the drawer under the living room couch and take care of them there. As children we were told: 'The cat is searching for a place to have her litter. Leave her be. Don't touch them until she brings them to you, otherwise she could abandon them.' From that initiation into the wondrous creation of life, I am at home with the smell of amniotic fluid and familiar with the music that kittens make extremely pleased when breastfeeding.

I sing praise to gifts that remarkably visit us abruptly, one marvels at the other, each of them startlingly short-lived.

Do we ever witness a natural childbirth? No. What we usually see on television, in film or even in commercials does not count. It has the characteristics of something that people try to depict as the truth, but is far from it.

Are the students of obstetrics present, actually present, at physiological births before they start learning about the deviations from normal, studying complications and being trained in treating or saving?

How are midwives being made wise today? The wives in the true sense of the word. Women of deliberate life experiences, really wise women or sages femmes as French midwives are called. Do they satisfy the fundamental condition of midwifery?

We can start solving the problems of modern childbirth by reviewing the latest scientific findings regarding obstetrics and midwifery, and their consideration in perinatal care. In order to grasp the magnitude of this subject matter through culture, we need not only scientific consistency and accuracy, but also the sensitivity of art [see Art and Soul, edited by Lorna Davies]. While rethinking the basics of human birth, special consideration should be put into the use of language; and even more, to the use of poetry as a path.

Original midwifery is action directed towards the good of others, individual women and their babies, and consequently also of the community. The mission of midwives was often passed on through female relations, from mother to daughter or through initiation procedures, when the old recognised the talented candidates among young girls. The younger girls accompanied the more experienced women and learned by being present at births, participating in the activity, and by being patient and observant.

Brigitte Jordan describes how a traditional birthing assistant, a partera, introduced her to care of the pregnant women and their babies on the Yucatan peninsula. Without any introduction or words of explanation, she simply took the scientist's hands in hers and led them across the round belly, enabling her to see by feeling the position of the baby and at the same time learn the right massage movements.

The preserved testimonies of ancient birth cultures speak of a wealth of wisdom, such as recognising the progress of birth from the woman's breathing and sounds or by the sense of smell to establish rupture of the fetal membranes. We should not underestimate the symbolic measures that midwives proposed. The opening of all that was closed – for example windows and doors – was important in cases of delay in labour and is mentioned in numerous versions by different ethnologists. The path of a midwife's study was a path to realising her name. In old English, the word midwife means to be with a woman.

The traditional learning through accompanying and being present in childbirth began changing with the emergence of professions. One of the first steps to be taken by traditional birth assistants was the condition that they had been questioned and confirmed for providing midwifery services and that they had been sworn in. The next step was the foundation of vocational schools providing midwifery education. Initially, the conditions for enrolment included the women's experience, maturity and ethics, which were related to their age, marital status and the number of children. These conditions were later abolished. It is no coincidence that pregnant women often doubted young midwives, thinking there is not much help to be had from a scholarly girl, who has not even tasted life when she does not have any life experiences and has not even given birth herself, and placed more trust in traditional birth attendants.

Development of midwifery, marked by increasing medicalisation, institutionalisation and use of technology, means that modern midwives have a lot of knowledge and experience with medical childbirths, yet are in a similar situation to a person who learned to swim in a bathtub being lured by the ocean.

In order to revive midwifery we need to find a path to the mastery. One which will balance theoretical knowledge with the acquiring of experiences: first, by accompanying independent midwives during physiological pregnancies and births and caring for mother and child, and later, with learning and active participation. In order for midwives to act as independent experts, the more progressive ones are already taking the path that joins two parallel currents which complete each other like the strands of the DNA double helix. The first current runs in the direction of strengthening the midwifery autonomy that is based on recognising the nature of childbirth and on comprehending the basic elements of midwifery. This leads to more in-depth knowledge and skills and to their introduction to everyday midwifery practices regardless

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

These photos are an invitation to a journey along the path of understanding the differences between the prevailing forms of childbirth and a physiological birth. With thanks to the mother, the father and the child for this exceptional gift.

of the institutional frameworks. The second current runs in the direction of developing cooperation abilities, especially cooperation with the individual, and always with the special birthing woman, the child who is coming to this world, their loved ones and other professionals who are included in perinatal care as required, in the mutual striving to ensure conditions for its realisation. Such cooperation also means that excessive commitment to external rules which may become an obstacle in providing excellent care is balanced.

Midwifery is the sensitive search for balance between internal orientation towards the development of science and the formalisation of actions, and the direction towards those women, babies and families, who are being born in front of their eyes and who give midwives the right to their name. When opening and yielding to birth, the woman legitimately expects the assurance of the community, which is provided through its representatives, the midwives, that what can feel like the chaos of birth is actually part of the natural order of things. In this sense, the midwives are the positive aspects of the images of Ancient Mother and Mother Nature.

The loss of contact with midwifery tradition is not the only problem faced by women as mothers and as contemporary midwives. The interrupted current of female tradition results in a striking lack of knowledge of the abilities of a female body. Despite the multitude of data, perhaps even excess information, pregnant women often feel as though they are lacking substance before the great event, and have difficulty finding assurance within themselves. While growing up, direct and indirect answers to important questions on birth are of key importance in forming their notions of future motherhood. What are the messages of our culture if adult women, half in hope and half in fear, ask: 'How can I give birth to a three-and-a-half kilo baby without being injured? It must hurt. Wouldn't it be better to have a caesarean?'

However, unlike soldiers, who give their lives for their country, women have the ability to give life differently. The condition of our gift is not our own death or end of existence. On the contrary. A woman on her way to motherhood, a pregnant woman, who is getting round and gaining curves, who is getting fuller in an inwards-directed concentric coating from the skin through the layers of muscles, uterus walls, fetal membranes and the placenta, is cradling the core of life. There are two hearts beating inside her. If she is carrying twins or more, there are even more hearts, which is a unique physical, mental and spiritual experience: two entities in one. This is related to becoming focused on oneself on the inside and a special glow on the outside that those who pay attention notice and ask: 'Are you expecting?'

This is a task that surpasses us as individuals, as new life springs up and develops within us, while the actual birth means that humankind is being linked and continued through us. A pregnant woman repeats the miraculous story of motherhood by her predecessor and her ancestresses, which is written in her organism on a biological level in order for humankind to continue.

The relationship between mother and child, which requires nine months of patient waiting, nurturing of hope and careful internal listening, is the archetype of human cohabitation that leads from the newborn phase to human freedom as the child grows up.

Modern insights into life processes in the female body discover sensitive and co-dependent aspects, for example on the hormonal level, which enable, impede or even prevent conception, pregnancy, birth, lactation and breastfeeding. The latest scientific findings on the nature of motherhood (and fatherhood) inspire deep respect, and enable us to re-evaluate the values that served as the basis for fertility worship in traditional cultures. This is not merely a new and different understanding of the past. These findings direct us to consider the conditions under which the women of today are becoming mothers.

No woman is outside of culture. We are born into it and are marked by language and interspersed with meanings and roles that define what being a woman means. There are other notions that mark us: how to eat and how to secrete, how to see to one's hygiene and how to care for one's body, how and when to make love, how to act as a pregnant woman, how and where to give birth, who should be present, what way of expressing pain and other feelings is acceptable, which position of the body is appropriate and which not. Cultural forms strictly shape motherhood, habits and rituals connected to pregnancy and childbirth, as well as the desired and expected behaviour and restraints of an individual woman, who internalises social expectations and norms. The physiology and culture of a woman, her personal story and family tradition can be in contradiction during the pregnancy, while the stress is even more evident in the actual act of giving birth.

There are always women who experience and act

The image of giving birth offered by the media, showing a woman screaming in agony, could not be more different from the images of a physiological birth.

Our civilisation places a positive stress and value on technology and dictates control over the body and its functions through interventions and medication. It demands external control over its functions, submission to norms and dictates a tempo that cuts through time like a metronome, so that a feeling of a constant need for an even greater haste emerges and that an unbearable lack of any kind of peaceful moments occurs. In a culture, that appreciates self-control and objectification of the body, a woman may experience the forces of natural birth, its undulation and inevitability as crossing the lines, and letting go can be problematic or even unacceptable. This is joined by a fundamental mistrust of nature, the incomprehension of its rhythms and the fear of its apparent disorder that some see as chaos that urgently needs to be limited. Modern birth assistance is characterised by technology, medical procedures and drugs which are quickly and often unjustifiably given preference over waiting, patience and trust. The notion of the modern woman's inability to give birth spontaneously is growing stronger on individual and cultural levels due to medicated childbirth and its transition to healthcare facilities with an almost routine use of induced contractions and the prevailing passivity, which is characterised also by the woman lying on the bed during labour.

Scientific findings, research results and consistent deliberations allow us to be very aware of how important it is to consider the internal limits of medicine: carefully considered medical help, drugs and procedures during childbirth allow medical experts to maintain health and life, so we are thankful for the possibility of safe caesarean surgery and pain alleviation medicine. However, excessive use of interventions during childbirth, or their unfounded misuse, brings increased short- and long-term risks to the health and life of mother and child, regardless of whether we are speaking of excessive use of drugs for induction and augmentation or episiotomies.

This set of problems also includes the advertising of different kinds of analgesics as the final salvation of birthing women, with a view of labour pain as senseless suffering. We urgently need to re-question the causes and purpose of labour pain and our further choices regarding this pain.

Fortunately, faith in technology over nature does not permeate society without exception. There are always women who experience and act differently.

What would a healthy woman spontaneously do if she was giving birth following her body's messages? She would find support in her loved one or be alone, somewhat away from her loved ones, but still within their reach, perhaps somewhere in a darkened shelter. She would connect with her baby and her body's feelings. She would close her eyes and move with the flow. If she was giving birth in nature, she would lean on a tree, hold on to a branch or crouch down in the warm sea. She would not fight the force and the strong feelings that are spreading her body as never before.

Would she lie down? Definitely not on her back. She would rest occasionally. She would probably take a few sips every now and then; perhaps rhythmically repeat a simple song, mantra or prayer. Just before giving birth, she would sit up, perhaps crouch, lean her head backwards and probably make deep guttural sounds. When the baby was born, she would slowly lift it in her arms and be amazed. In soft light, the baby would open its eyes and look at her, and at some point, they would start breastfeeding.

Would it hurt? Probably, but not unbearably. The pain would depend on the game played by the two main, and at the same time, antagonistic hormones – adrenaline related to fear and oxytocin, the hormone of opening and love – and the connection between mother and child.

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

Those who fear, have three main options: flee, fight, freeze. Each of these choices can be an excellent way out of a dangerous situation, as they increase chances of survival. However, none of these is sensible for giving birth to a newborn baby, who in order to be born needs a safe environment and the calm focus of his mother. When messages from the environment are felt as a warning about danger, the body needs to be ready for swift and effective movement: digestion slows down, muscle blood flow increases and attention is focused outwards. In such a case, childbirth will temporarily come to a standstill, as it would be senseless to bring the baby into danger. This is why fear is unwanted in childbirth. The chemical password for a good and safe childbirth is therefore: less adrenaline (as little as possible), more oxytocin (as much as possible) and related natural pain relievers that automatically occur in the mother's body during physiological birth.

The essence of birth activity lies in the cooperation between the child and its mother, whose spontaneous movements and changing of positions are a reaction to what her body is feeling, even to pain. Special types of pain during labour are a warning to the woman and those who support her that something might be happening which requires an intervention, procedure or medication. When the sense of pain is numbed, these messages are lost, which can result in late recognition of problems.

Everything that leads to lower fear and stress levels, that leads to relaxation, resignation, peace and trust, that reduces activities of the neocortex, such as thinking and speaking, alleviates labour pain. Movement, rocking, dancing, using water, mediation, visualisation, breathing techniques together with vocalisation and signing, touching, from caresses to massage, are all non-pharmacological methods of pain relief.

We know that female primates do not give birth if they feel they are being watched. This applies to human mothers. In order to give birth, they require an environment that they perceive as safe and private, and where they feel good enough to close their eyes. In our culture, this privacy is related to the feeling of being home, and most intimately, in the privacy of one's bedroom or bathroom. Monitoring birth is too often tied to a controlling view, vaginal examinations that are sometimes performed inconsiderately and painfully and with the use of invasive technology.

Changing the fundamental understanding of the birthing process means allowing physiological processes to be fully operational. Attempts to turn the sterile white walls into a domestic environment by painting them in lively colours probably remain a superficial copy of homeliness. Visual messages are important, but they need to be intertwined by forming circumstances that allow the woman to connect through other senses, so the use of natural materials, such as soil, wood, stone and water in different shapes, contact with nature in its transformations of light, voices, living beings, the interaction of air and music can be crucial. The indirect environment, comfort, warmth and the possibility of dark, enables the connection between the internal and external and needs to be carefully and attentively designed and nurtured. Above all, an environment with human presence needs to be created. Those present in birth to ensure safety of the child and the mother must also respect space for privacy, which is individually and culturally changeable.

Bright illumination can be disturbing to both the birthing woman and the baby, who has spent months living in a world of blurred images and is looking into his mother's and father's eyes for the first time, and is starting to learn to watch and see the world and himself. One of the key tasks of midwifery care is to express tenderness in presence and touch.

I sing praise to love, which stays to the last, a tiniest bird singing a comforting song I will never forget it again.

Excellent midwives are filled with love for the wisdom of childbirth, they are at the intersection of nature and culture, of the best that culture can give and the good which is the natural abilities of women and babies and which enables childbirth. This wisdom requires modern birth assistants to recognise and consider it swiftly.

On the level of community, we are facing the challenge of how to unite the best in medicine and midwifery with cultural transformation. The time for strengthening endeavours to create different memories for the future of our daughters and granddaughters has matured. Let us think about the gift that our birth stories create and give today. Let us discover the knowledge about the wisdom of the female body in our biological and cultural past. Let us bear witness to the pain and joy of birth.

The child moves from limited space to the wide expanse of external nature with its temporal and spatial infinities. This is a change that has no comparison. A spontaneous birth means travelling through pain into joy that is written on the faces of women, their children, fathers and all who are bathed in the oxytocin. In the fullness of the experience, they are tuned by the stunning meeting of all meetings, the meeting with happiness. The mirror game of love can begin.

Zalka Drglin

Poetry taken from Edvard Kocbek's Mala hvalnica, Lesser Psalm, from the Velike pesmi cycle. Translated by Michael Biggins, www.thezaurus.com/?/literature/kocbek_edvard_lesser_psalm/

Further reading

Davies, L (2007) The Art and Soul of Midwifery: Creativity in Practice, Education and Research. Churchill Livingstone.

Davis-Floyd, R (1992) Birth as an American Rite of Passage. University of California Press.

Drglin, Z (2008) Rojstna mašinerija. Sodobne obporodne vednosti in prakse na Slovenskem, Založba Annales, Koper . In Slovene language.

Gaskin, IM (2003) Ina May's Guide to Childbirth. Bantam.

Jordan, B (1993) Birth in Four Cultures: A Cross-Cultural Investigation of Childbirth in Yucatan, Holland, Sweden, and United States. Waveland Press.

Rožič, J, Izhodišča (2008) In Pleterski, A, Belak, M (ur.) Sporočila prostora, Založba ZRC, Ljubljana, 2008, p. 9-17. In Slovene language.

Združenje Naravničzačetki, Natural Beginnings Society, www.mamazofa.org.

Report

Farce or Tragedy?

Donal Kerry looks at the ongoing case of Dr Ágnes Geréb

Dr Ágnes Geréb returned to the Hungarian courts on 6 December 2012 to defend herself in another round of unnecessary cases brought by the State Prosecutor's Office. If the whole situation wasn't so painful for Ágnes and her family, you would easily be forgiven for thinking this was the plot of another outrageous Alan Ayckbourn farce:

Scene1: home birth mothers with constitutional rights being supported by Ágnes but the State attacking these rights by attacking Ágnes, and then the European Court of Human Rights (ECHR, Dec, 2010 Ternovsky ruling) having to intervene to stop the Hungarian State from abusing its own birthing mothers and their midwifery carers!

Scene 2: 6 December, 2012 and the prosecution lay the charge before the court of 'quackery' against Ágnes, arrogantly citing 200 parents as evidence in their case only to find the same 200 parents presenting themselves as defence witnesses for Ágnes!

Farce or tragedy? You decide! But surely it is now time for this to end and instead to take the calm signal given by the Hungarian President last October, which should help provoke reflection for everyone involved and a motivation for all with influence to try to find a just solution.

As illustrated above, it's crystal-clear that Ágnes Geréb's court cases have never been about getting to the truth of any particular birth situation. Anybody who knows her or any truly caring and committed with-woman midwife will know that their first and only concern is always and totally for the mother and her baby. Midwives like Ágnes don't intentionally set out to commit crimes. In fact, they are so emotionally and professionally committed to the support of the mother and baby that if something does go wrong they are unforgiving of themselves and usually quite devastated by the adverse event. That's how it is for Ágnes now and that's how it will always be for midwives in these situations.

The case of Ágnes Geréb is really the case of all midwives in Hungary and Eastern Europe, and indeed the case of the birthing mothers they support. For a whole heap of historical, social and political reasons, both birthing mothers and the midwifery professionals in this region are subjugated. Each group is unable to enjoy their full legal, human and professional rights because of a dominant obstetrics profession and a medicalised model of maternity care traditionally supported by government. Hungarian hospital midwives are not legally entitled to deliver babies and their primary function is to assist the doctors. Birthing mothers are conditioned to defer to the expertise and supremacy of the doctors and they expect to experience a highly interventionist birth on the misleading grounds of safety.

Maternity doctors enjoy and are accustomed to their position of power but critically they also need it because they are so poorly paid by the government. To counter their poor pay they expect and receive very significant supplementary income in the form of the 'untaxed gratuities' that parents feel obliged to offer them during the pregnancy and delivery. Anyone like Ágnes, who so powerfully represents the rights of mothers and midwives, is a threat to this status quo and that is the real backdrop to all her court cases. The question now is how to encourage the doctors to relinquish some of their control, allowing mothers and midwives to determine the type of maternity services provided in Hungary.

The answer requires multiple actions, beginning with the government's need to improve public health staff pay levels so that doctors' domination of the maternity service isn't motivated by personal economics. Hospital midwives need improved training and skills so that they can confidently and safely support normal births without the presence of a doctor, and new regulations must support this as a legal fact. Independent midwives must have full ante and post natal access to mothers planning home births. Current excessive restrictions and costs on mothers wishing to birth at home, and the midwives wishing to help them do this, must be reduced. Birthing mothers must also have their birth-care costs covered by their public health insurance contributions, irrespective of whether they have their baby in hospital or at home, which is currently not the case.

If there is any good news in all that Ágnes and her family have had to suffer, it's that her case has now set the agenda for the reforms to the Hungarian maternity services that are so badly needed. The question is not whether these changes will come but when will they arrive? And, will they be brought about through sensible dialogue involving all relevant parties or only after overcoming more resistance on the part of the doctors and continued passivity on the part of the government? There is a point when this tragic farce will end for Ágnes and her family and she will rightfully reclaim the freedom she so richly deserves, and when she does it is hoped that Hungarian maternity services and care will have progressed to a better place.

Donal Kerry

AIMS Comment

By rather absurd contrast to the situation in her home country, on 19 March 2013 the Danish foundation *'A Good Start in Life'* awarded their 2013 professional prize to Dr Ágnes Geréb. www.szuleteshaz.hu/danish-foundation-a-good-start-in-life-award-their-2013-professional-prize-to-dr-ágnes-geréb/?lang=en

For further information please contact:
Campaign for Justice for Ágnes Geréb
donalkerry@hotmail.com

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

Postpartum Aggravation

Alicja Piotrowska describes her experiences of postnatal intervention

We found out we were having our first baby in September 2010. I was a healthy 23 year old, and my partner and I felt very happy and relaxed about it. We both wanted a natural home birth with no stress and minimal intervention. We felt confident that everything was going to be fine and trusted in birth as a natural process.

During the pregnancy I chose to decline ultrasound scans and doppler to detect fetal heart. I was Rhesus negative while my partner's blood group was positive, and I chose to decline Anti-D injections during the pregnancy, accepting only the one at 72 hours post-partum. I had no other health risks.

Our midwife was one of, if not *the,* most oversubscribed midwives in Leeds, with a caseload of over 100. She was very detached in her interaction with me; she couldn't remember who I was over the phone and got my name wrong. When my partner came in to an appointment with me she didn't acknowledge him at all: basically we felt she couldn't care less. We employed a doula, went to NCT antenatal classes and did a lot of birth-related research. Because we were unhappy with our midwife, our doula arranged for us to meet up with the manager of the midwives towards the end of the pregnancy to discuss our situation and birth plan. After meeting with her, we agreed for her to replace our previous midwife for the remainder of the pregnancy.

On 3 May 2011, I went into labour, and from 12am until just after 4.30am I was in active labour, waiting for the midwives to arrive to check my progress so I could push. The midwives arrived at our house at 4.10am, came upstairs at 4.30am and our daughter Rosa-Maria was born at 5.00am after only 20 minutes of pushing. At 05:15 the placenta was delivered, a cord sample taken in order to check for antibodies as I hadn't received the Anti-D injection and my partner and I went to bed with our baby, where basic checks of my temperature and blood pressure, along with temperature and weight of baby were done.

We were very tired and very happy.

In terms of my experience of labour and birth, I had a great time. I was very vocal and relaxed and enjoyed the whole process, although I couldn't understand why the midwives took so long to come up and tell me how dilated I was. The midwives seemed very unsure of what was happening and very uncertain of themselves and the situation. In the birth notes they have written, 'can hear screams upstairs.' We read the birth notes after the birth and noticed they had circled me as 'High Risk', and had called the maternity supervisor before going upstairs to see me, she had advised them to document everything – still not sure why they thought I was high risk – perhaps because I had had no scans, and because my baby was back to back (potentially) and it was at our house. The midwives stayed in the background as I birthed Rosa and my partner caught her. The birth itself was a very positive experience, I felt no stress and the moment that Rosa-Maria was born was a very happy one.

What happened over the next three days changed the experience of a good birth into one of harassment and anxiety.

We went to sleep after the birth of Rosa-Maria and basic checks at 7am. At 9am we received a voicemail saying the sample taken from the cord had shown a raised result so we needed to go into the hospital to have some more blood tests done on Rosa-Maria to check SRB (bilirubin) levels. At 10am our new midwife and manager of midwives called to tell us the situation again, that we needed to go in to make sure Rosa-Maria didn't need treatment. We asked whether the blood tests could be performed at home, as we were very tired and needed rest; we were told that the blood tests must be done at the hospital as the SRB needed to be intravenous and only a paediatrician could perform the test.

We told the midwife we would go into hospital in a bit; we needed to eat and sleep first, as we'd been up all night. We then slept. At 3:36pm we got another call from her, now exerting more pressure on us, talking about the worst-case scenario, that Rosa could get brain damage, that we must go in straightaway. We asked her for more details regarding the condition of haemolytic disease of the newborn, and we noted that Rosa was not symptomatic at all, being very pink and looking in perfect health. We repeated that we would go in, but within reasonable time; we were not going to rush in after having been up all night. I could see and feel that Rosa was fine and that the test was a routine one. We spoke to the hospital to get more information and again they threatened us with the worst-case scenario, and mentioned calling social services if we didn't go in. At no point had we said we wouldn't go in. At 6pm we arranged for our doula to pick us up to take us to hospital; we arrived at 7.30pm, where there was no sense of emergency. We saw the paediatrician who performed some checks on Rosa, taking three heel-prick tests – no intravenous test – and asked us to wait an hour for the results. We decided to go home and wait for the results by phone.

No one offered me the Anti-D injection.

We got home and at 10pm we went to bed, exhausted, after eating, and at 10:40pm we received a call from the paediatrician giving us the all-clear on the bilirubin levels. We turned our phones on silent and settled for the night. Soon after this, at 11:17pm, there was a missed call from the paediatrician, this time with results from the other blood tests (PCV – packed cell volume), saying the results

AIMS HELPLINE: 0300 365 0663
helpline@aims.org.uk

were raised and they wanted us to come back in immediately for further tests, this time intravenous. We were asleep and missed the call.

At about 3am there was loud banging on the door downstairs, repeatedly. This sound made my stomach turn. Rosa was not even 24 hours old and it was our first night together. We were completely exhausted and did not answer the door, and after several series of continued, loud bangs it stopped. It completely unsettled all of us and Rosa was crying throughout the night; none of us could settle. At 7:30am we found a note from a different midwife who had been sent by the neonatal consultant, telling us we must go to the hospital at the latest by 7am to perform more tests on Rosa and at 9:41am the midwifery manager left a voicemail telling us we must go in for more tests as the results were 'quite abnormal'.

Rosa was absolutely fine

I was exhausted, in shock at the banging on the door and the relentless phone calls and messages telling us we needed to go in for tests and potential treatment, knowing instinctively that Rosa was absolutely fine. We decided to speak to the midwifery manager and the hospital to tell them that we would go in again, but we needed some respite, as what Rosa and I needed more than tests was some time to ourselves. From this point I stopped answering my phone, and my partner negotiated with Pat and the hospital, explaining that we would go in, but not straightaway, and that when we did go in, we would be seen to immediately, we would not be waiting around.

At 4pm returning from the park, I went to bed while my partner made some food, but was woken at 5pm with more banging on the door and raised voices downstairs. Not again! Rosa was asleep so I went down to find another midwife had interrupted my partner cooking, telling him she'd come to do a postnatal check-up on me, and telling him that we needed to go into hospital. We confirmed with her that we would go into hospital once we'd eaten, which she was preventing us from doing. She began to ask me about my pelvic floor exercises, and I asked her whether we could leave the check for another time. She continued to ask questions regardless of this, which I answered as quickly as I could, and eventually she left, posting a letter through the door saying the following:

Sorry Alicja.
I know you need family time but just to clarify – you will need to attend Ward 56 for blood testing also – wasn't sure if I made that clear. See you Sunday. Enjoy your baby in the meantime.
Carole

After this I saw on my phone missed calls, texts and voicemails from a number of NHS figures; one text was from the midwifery manager, telling us she was sending round a midwife for the postnatal check-up, explaining why she had turned up and acted the way she did.

At this point we spoke to AIMS, via referral from our doula and we were advised to document everything that happens, and given points on ways in which to deal with and speak with the NHS; to give them time frames within which to contact us, and that anything outside of these time frames we considered harassment.

At 9pm we went into hospital, and the paediatrician performed more physical checks on Rosa, suggesting that the day before she hadn't done a full check-up. Intravenous blood was taken from the left hand; a heel prick was taken to check serum bilirubin (SBR) levels (it is routine when raised bilirubin levels are found to perform the same test for the next 3-4 days to see if the levels rise or fall); treatment lines were explained to us and documented. Rosa's results at 15 hrs of age were only a little outside of the normal range.

Anti-D injection and blood test were administered to me. We arranged for the results to be given over the phone, and gave contact hours. At 11:30pm we arrived home to receive a call saying the results of PCV were all fine and that the SBR levels had decreased again. The next day was Thursday; Rosa was two days old; we had one call from a midwife to perform the SBR test. AIMS had sent us contact details for a haematologist and a senior independent midwife, who we contacted on Friday, and they were able to give us more information and reassurance that the haemoglobin levels were, in fact, fine. On the Friday we had Rosa's results again and it was agreed that no more SBR tests were necessary. We had one more postnatal visit on Sunday 8 May and that was the end of the initial postnatal checks with the NHS.

We felt harassed and bullied during the first few days of our baby's life

We felt harassed and bullied during the first few days of our baby's life. Despite the fact that we agreed to go into hospital on the day of her birth, the intravenous blood test that we had been told was necessary wasn't done, so we could have stayed at home and they could have performed the blood test at home, relieving us of all the time spent on the phone, all the hassle and pressure. The staff didn't perform a full paediatric check on Rosa and didn't give me the Anti-D injection. When we got home that night, they gave us the all-clear when they hadn't received all of the test results.

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

When the second set of results came back on the first night, and they sent a midwife banging on the door in the middle of the night to tell us to go in immediately, we believe this was to cover themselves in case anything did happen to Rosa, as it would have been their fault for giving us the all-clear before all the results were back.

The midwives we were in contact with on 3 and 4 May were extremely bullying, aggressive, and insensitive towards us and our situation. They were constantly threatening us with the worst-case scenario as if it was happening at the time. They exerted unreasonable pressure on us and did not listen to what we had to say. We were patronised by the hospital staff over the phone and during the first visit to the hospital, who treated us as if we were very strange for acting the way we did.

We believe that the midwifery manager took our situation personally: firstly, because she had taken over from our previous midwife, and perhaps saw us as one of those 'special cases' due to the fact we had had no scans and were very clear that we wanted a natural birth, and secondly, because she was going on holiday the next day and wanted to have the whole thing sorted. She became extremely impatient with us. Over the phone to my partner she expressed her frustration that we wouldn't just do what she said, that she was going on holiday the next day and was looking forward to it all being over and done with.

I feel as though, after all the hard work we did in preparation for and during the birth to ensure it would be natural, we were robbed of the very special time of the first days with our daughter. We worked hard to ensure that we would allow our baby to arrive in her own time, which she did, and I focus on this, in face of what happened so soon after her arrival.

I am sure that if we had a midwife who listened rather than bullied, the situation would have been very different.

The SBR and PCV test results were both only of borderline concern. Rosa's bilirubin levels were always well below the threshold for recommending treatment, and Rosa showed practically no sign of jaundice, which was documented by both the paediatrician and the midwives who came to see us on the third day. The fact that the midwifery manager referred to the PCV results as 'quite abnormal' does not pertain to the actual results, which were only slightly outside the normal range. Our daughter was always fine, never jaundiced, and we were never against having any tests performed to confirm this. We are shocked at how the NHS responded to and dealt with our situation. At no point did we ever say we would not go in to hospital. We said we would go in, within a reasonable time, once we had rest. It was the NHS that prevented us from getting any rest, because they were constantly calling, threatening and harassing us.

My partner and I are very grateful to AIMS for the support they gave us during this time. It helped us to manage the situation and prevent any further harassment, and it has given us the information we need to be able to deal with the NHS effectively in the future.

Alicja Piotrowska

Withholding the Truth

The misoprostol debate continues. In Denmark, in 2012 a woman was given misoprostol to induce labour even though she specifically asked not to have it. The midwife said, 'We do not use cytotec in this labour department, it is only used for abortions.' They then gave her 50 microgram misoprostol (cytotec is Pfizer's brand name for the generic drug misoprostol, a synthetic prostaglandin E1). The woman thought that she had been given the licensed drug minprostin and swallowed it. Only later did she realise that something was wrong – the dose did not match minprostin. She called the labour ward and they confirmed her fear: she had been given misoprostol.

The chief obstetrician was asked if women can have the licensed drug if they do not want misoprostol and he answered: *'We have not taken a position on it, it depends on the situation. But you can't have everything on our shelves. Of course you can have a discussion about it and we would advise against using anything other than what is our standard treatment [misoprostol], but of course if you keep on arguing then you might get it done differently in the end.'*

So what does this mean? Only those women who are strong enough to keep arguing should have an informed choice?

This is not isolated to Denmark. AIMS knows of at least two women in the UK who have been given misoprostol against their wishes. One woman who had a prior caesarean scar suffered a rupture as a result of treatment with misoprostol as a pessary; she was under the impression that she was being treated with prostin (Pfizer's prostin E2, a naturally occurring prostaglandin E2 (PGE2), licensed for inducing labour) for a second trimester miscarriage. She only discovered the truth after she had sustained damage. What is even more worrying is that the medical staff treating her did not seem to appreciate that the two drugs are different in composition, action and risk.

AIMS has been on the trail of misoprostol since 2001; see AIMS Journals Vol 13 No 3, Vol 14 No 4, Vol 16 No 3, Vol 17 No 1 and www.aims.org.uk/misoprostol.htm

Reviews

Where Have All the Mothers Gone? Stories of Courage and Hope during Childbirth among the World's Poorest Women
By Jean Chamberlain Froese
Fresh Heart; 2nd edition 2011
ISBN-13: 978-1906619268
publisher's recommended price £21.00

As someone who worked in Uganda, albeit for only a short time, this book helped make sense of some of the more political thoughts I had during my time there.

The book offered an excellent insight into how mothers are at risk from their environment, rather than birth itself, but it would have been very much enhanced by actually exploring how the conditions under which these women were living, becoming pregnant, birthing and raising their children affect their life expectancy and their safety.

It is a shame that for many of the stories the part of the situation that was highlighted was the poor access to medical care, without mentioning that if the women were healthy, safe, well-nourished, freed from genital mutilation and with access to sanitation and clean water in their day-to-day lives, they would need a lot less rescuing with medical attention.

It struck me that if one in 30 women in the world's poorest nations actually die from birth, this is indeed appalling. The stories, however, highlight how women are being deprived of the most basic of needs and this is the real concern. When women are endangered because roads are being blown up in war zones, thus denying them a safe transfer in the event of an emergency, that has nothing to do with the safety of the birth process; the woman would have been in equal danger from a roadblock had her injury been a knife wound or a snake bite.

Women are experiencing deadly postpartum haemorrhage because they are seriously anaemic. This is not due to the woman not caring for herself or any danger inherent in pregnancy or birth, but because of the economic and social climate in which she lives. Things such as the land not being irrigated adequately to offer her a healthy diet and inadequate access to clean drinking water are deadly, yet this book makes no mention of that, preferring instead to blame pregnancy and birth. Women are working hard at, or even below, the very limit of adequate nutrition, and it is the poor nutrition that is taking its toll, not the physical work or pregnancy.

Undoubtedly there are some very dedicated professionals who are working to save women and babies, but they are saving them from the catastrophic effects of poor living conditions, war, economic and environmental disasters, corrupt governments and a general devaluing of women and children, rather than from the dangers of birthing itself.

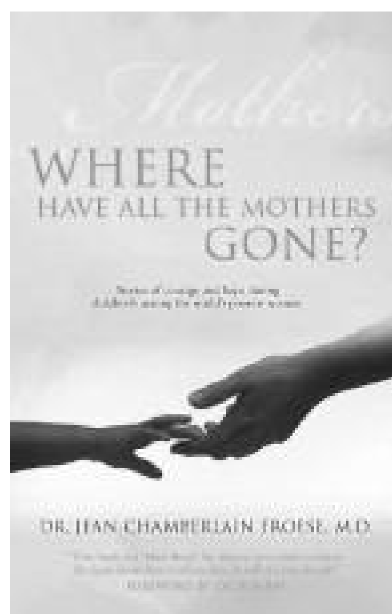
The tradition of herbal remedies amongst birthing attendants is probably less of a concern than the use of modern medical methods amongst those who have not had access to basic education, are unable to read instructions and have no hands-on wisdom to guide safe use. This is not because birth, traditional medicine or traditional attendants are dangerous, it is the volatile cocktail of low education due to control of government monies combined with only part of the technology needed to complete a task. Again this is more like the situation where tractors are provided without fuel, preventing their proper use, than it is a statement on the safety of childbirth or traditional attendants.

This book indeed highlights not the need for increased medicalisation of birth, but the acknowledgement of all those things that hinder the woman from safe birthing process, and if help is needed, how man again hinders this assistance. Sadly, this book does not explore these themes in any depth, and for me, that is a major omission.

For this country, there is much to learn. With a mind trained for critical analysis, if in the worst-case scenario suggested by this book, 1 in 30 (3.33%) women were really to die from birth itself (rather than environmental factors affecting birthing women), then why is our caesarean surgery rate 25%, almost 10 times that rate when we are well-nourished, safe and well-housed? Given even the most cautious of practice, on the basis of evidence presented in this book a 5% caesarean rate would be just about justifiable to 'save' women's lives. This evidence strongly suggests that the high-income countries' high intervention rates are quite possibly the reasons behind their high caesarean rates, rather than the 'risky' business of birth itself.

In all, a book with more questions than answers, but an interesting read all the same.

Kate Simpson



Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK

Toxic Maternity

Beverley Beech elaborates on the curious case of Greek placentas

Women who give birth at home in the UK, and in many areas of Europe, have a choice as to what they do with their placentas. The midwife may dispose of it, in which case she will take it to the nearest maternity unit and add it to their waste disposal system; or a woman may choose to keep it, consume it, dry it to make placenta capsules or bury it in the garden. If they bury it in the garden they often plant a commemorative tree or rose bush over it.

'Maori bury the placenta to emphasise the link between the baby and the earth. The Nepalese think of the placenta as the baby's friend. Malaysian Orang Asli regard it as the baby's older sibling. In Nigeria the Ibo conduct full funeral rites for what they see as the baby's twin. Native Hawaiians traditionally plant the placenta with a tree, which can then grow alongside the child.'[1]

The placenta is the woman's property and she is entitled to dispose of it as she wishes. Women who birth in hospital often ask to take their placenta home rather than leave it in the hospital for disposal.

'Some women may wish to take their placenta home with them, so it is important that the midwife double bags it and places it in a suitable container.'[2]

Some women have their placentas made into capsules which they take over the following weeks as a means of preventing postnatal depression. Women who take placenta capsules report fewer emotional issues, more energy and a faster, more pleasant postpartum recovery. Chinese women have done this for centuries.

In Greece, however, disposal of the placenta has become a legal controversy, provoked by the Midwifery Association of Thessaloniki. Their President, Viktoria Moschaki, and two secretaries, Garifallia Michalaki and Antonia Artimaki, have taken legal action in Thessaloniki's High Court against 69 parents, nine doctors and one midwife alleging that the doctors were persuaded (by the parents) to sign forged medical certificates about the 'alleged' birth of the babies – suggesting that they are involved in baby trafficking. Apparently, these deluded obstetric nurses (I hesitate to call them midwives) are implying in their allegations that there is no evidence that the women gave birth, or that they were ever pregnant! All the women had chosen to birth at home, with a local midwife, and it appears that the Midwifery Association of Thessaloniki views this as an activity to be stamped out vigorously – despite the research evidence that fit and healthy women and babies are safer birthing at home than in an obstetric unit.

In order to bring the prosecution the prosecutors, acting for Viktoria Moschaki et al, trawled through the birth records of women who had registered home births in Northern Greece between 2009 and 2010, most of whom lived in Thessaloniki.

The second allegation is downright farcical. They allege that a placenta is *'highly dangerous human waste'* (how do women survive growing this toxic substance within them?) and it has to be disposed of by the local toxic waste systems. To add weight to this allegation they claim that the placentas ended up in garbage containers. They have no evidence whatsoever to support this allegation, and the mothers have their evidence in their gardens (mostly sitting under a tree or bush had Viktoria Moschaki and her co-conspirators bothered to conduct some soil analysis). So enthusiastic is Viktoria Moschaki to bring these ridiculous prosecutions that she omitted to ask the mothers what they did with their placentas.

toxic waste

Viktoria Moschaki, in her enthusiasm to wipe out independent midwifery in Greece, is trying to apply hospital regulation for the disposal of enormous numbers of placentae, which, collectively, would qualify as *'toxic waste'*, to the disposal of a single placenta following a birth at home. Interestingly, this *'toxic waste'* is eagerly accepted by the cosmetic industry to make many cosmetics – so much for toxicity.

Birth registration offices in Greece do not accept birth certificates that are not signed by a doctor, despite the fact that the law allows the certificates to be signed by a midwife or the father. So, one of the parents (for example) had their baby checked by a paediatrician shortly after the birth and asked her to sign the certificate. She did so, stating that birth was attended by a midwife. The allegations against her are that she falsified the form and the suggestion is that she is involved in baby trafficking!

Home birth in Greece is not illegal, but Victoria Moschaki is determined to stamp it out and this ludicrous prosecution is her latest attempt. One trusts that the judge will have more sense and throw this case out and the parents will then consider prosecuting Victoria Moschaki and her co-conspirators for a malicious prosecution and a gross breach of confidentiality for trawling through the families' records to justify this outrageous case.

Beverley A Lawrence Beech
Hon Chair
Association for Improvements in the Maternity Services

References

1. Black M (2008). The Bigger Picture, Placenta Tales, British Medical Journal, 27 June
2. Blackburn S (2008) Physiological third stage of labour and birth at home: In: Edwins J (Ed.). Community midwifery practice. Blackwell: Oxford.

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 choices, suggestions for ways to make VBAC more likely, and where to go to find support; includes real experiences of women. £8.00

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

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

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

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

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

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

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

Making a Complaint about Maternity Care by Beverley Lawrence Beech: The complaints system can appear to many as an impenetrable maze. For anyone thinking of making a complaint about their maternity care this guide gives information about the procedures, the pitfalls and the regulations. £3.00
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: Making the right choice of maternity care. £5.00

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

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

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

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

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?
- Induction: Do I Really Need It?
- 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
- Induction: Do I Really Need It?
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

To join AIMS or place an order visit www.aims.org.uk

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

Twitter @AIMS_online
Facebook www.facebook.com/AIMSUK