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ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

Commissioning Care

Building women-centred choice

Birth centres and home births

Manchester service reconfiguration

Antenatal education

Report on 'Freedom for Birth' premiere

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Cover Picture: © Alison Richardson. Katie and baby Leah, the 100th baby born in St Mary's Birth Centre. Pictured with midwife Karen Guthrie.

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Can we get a better deal?

Debbie Chippington Derrick and *Ruth Weston* consider the NHS reorganisation situation

We are about to see big changes in the way that maternity services are commissioned. In order for services to be provided that will truly meet the needs of women, their babies and their families, those of us who understand what constitutes high-quality maternity care are going to need to make sure a clear message reaches those who will be commissioning these services.

Reorganisation within the NHS and of the way services are to be commissioned is going to happen, and although there are serious concerns about what will happen to the NHS, and what impact this may have on the standard of health care, this may present some real opportunities for change in the structure of care within maternity. In April 2012 'Any Qualified Provider' came into force, allowing services from outside of the NHS to be offered and for patients to choose from a range of services. The NHS choices website has details of current services of this type www.nhs.uk/choiceintheNHS/Yourchoices/any-qualified-provider/Pages/aqp.aspx.

Any Qualified Provider status enables non-NHS organisations to be service providers commissioned by clinical commissioning groups (CCGs). It is into this structure and policy that providers One to One Midwives and Neighbourhood Midwives are integrating themselves, and it offers a potential opportunity for a reorganisation of care that could provide women with more continuity of care and receive it based more in their community.

The Government has made clear pledges about provision for maternity services which include:

- *Making sure the investment in a record 5,000 midwives currently in training means that women will have one named midwife who will oversee their care during pregnancy and after they have had their baby.*
- *Making sure that investment also means that every women [sic] has one-to-one midwife care during labour and birth.*
- *Making sure that investment means parents-to-be will get the best choice about where and how they give birth. The Government wants to see more joined-up working, so women can choose from a full range of services, meaning that choices made are delivered within an integrated, flexible service.*

Further details of the pledges that were made can be seen at mediacentre.dh.gov.uk/2012/05/16/nhs-pledges-more-support-for-women-with-postnatal-depression/.

If these pledges and the changes in the structure of the provision of care are to provide improved maternity services then women and their families are going to have to stand up and make it clear what they need and that the standard of the services currently provided to many women is not acceptable.

Women need midwives to be providing real 'with woman' midwifery care. If the current situation of so many unnecessary and damaging interventions is to change, women need their midwives to have had the opportunity to fully develop skills for supporting normal birth and keeping interventions to a minimum.

One-to-one care needs to be clearly defined and monitored to make sure that services being commissioned and paid to provide it are actually doing so. Access to home birth, free-standing and alongside midwifery units needs to be available in all areas of the country; it should not be a postcode lottery. Women need to be able to make truly informed decisions about the birth of their baby, and, in order to do so, midwifery care and a choice of places of birth need to be realistic, well-supported options.

We are being sold 'centralisation is good' by the medical establishment, but the needs of women are not being properly considered in this policy. There is a failure to recognise the need for local services that provide a high standard of support for women in the antenatal and postnatal periods and access to local facilities for birth. Women will continue to go into labour where they live and they need to be able to access services locally; they need midwives readily available to attend them in their homes and in local midwifery units. If the centralisation of obstetric units occurs without these local services, more women are going to give birth or encounter labour problems in transit, and we are going to see more mothers and babies suffer or die because of the failure to provide services locally.

In this Journal we hear how Manchester services have been reconfigured, taking valuable services away from women in some areas, with the impact being particularly serious for vulnerable women. Within that service we hear of how St Mary's Birth Centre in Salford provides a service that is valued by women and gives care that avoids unnecessary interventions that are damaging to women, babies and their families. Yet the promise of further units of this sort has not been kept; leaving thousands of women every year without this evidence-based option of care which would be safer for them and cheaper for the NHS.

We need to question the basis of this kind of decision-making when it is not in the interests of women's health, nor what they actually want. Maternity services have been reviewed previously and both the Winterton Report[1] and Changing Childbirth[2] have made it clear that changing the service to make it more woman-centred is essential for better outcomes.

We have good evidence about the sort of care that women want and care that makes birth safe and empowering, the sort of care that enables women to be well prepared for caring for their child, through the

postnatal period and onwards to adulthood. We need to ensure our government and commissioners fully value what a strong midwifery service can do for society as a whole, and not just for the short-term physical outcomes of a mother and baby. Good midwifery care can improve the health, both physical and psychological, of women, their babies, whole families and the wider society to which they belong.

The recent Birth Place Study has removed any question about whether midwifery services outside obstetric units are safe and effective; we now need all commissioners of maternity services to make sure that they are providing the full range of midwifery services: home birth, free-standing midwifery units and alongside units, as well as obstetric units. Every woman in the UK should be able to obtain support for a birth that will not be subjected to unnecessary and damaging interventions. Without midwifery units and well-supported home birth services, women will continue to be damaged, at a significant cost to themselves, their babies, their families, the NHS and society in general.

We are also coming to a critical point with insurance for midwives. In October 2013 midwives will be legally required to have professional indemnity insurance if they are providing care during birth. AIMS is very concerned about what this may mean for women who have, until now, been able to opt out of NHS care by employing a midwife independently. Many women who have turned to independent midwives in the past have done so because the NHS has not been able or willing to provide the care that they need. Sometimes this is because of the high-quality antenatal and postnatal support one-to-one care provides, and because they needed a known and trusted midwife to attend the birth. However, it has also included women with more complicated situations, such as those having breech babies or twins, where the NHS has proved unable or unwilling to find confident and competent midwives to support women who are making choices outside the basic offer of care. See www.aims.org.uk/?Campaigns/independentMidwifery.htm.

Unless we engage with service commissioners we are likely to find ourselves with a selection of large obstetric units that are well suited to those who provide obstetric care, but fail to meet the needs of women and babies and that also fail to meet the needs and skills of those who wish to provide good quality midwifery support. Service commissioners need to be well informed about the benefits of local services, in terms of both outcome and cost, and about the risks that large obstetric units present to the majority of mothers and babies.

We need commissioners to understand that research has shown that midwifery services improve outcomes for mothers and babies, and that failure to provide these services will mean that those commissioning the service are causing damage to some women for whom they are funding care, and that will incur further costs to address that damage. They need to understand that women who have unnecessary interventions will cost more to care for not only in that birth but also in future births, and that they may also require additional services to overcome physical or psychological trauma.

NICE measures outcomes in terms of QALYs (quality-adjusted life years) and makes decisions about funding based on these. If the QALYs of a good birth could really be considered, and the care put in place to make sure that services were achieving on this measure, then we would really have made a step forward, for everyone.

The structure of commissioning is only emerging as this Journal goes to press and there is a glut of information being produced. The 23rd Bulletin for proposed CCGs was published on 9 November 2012 (www.commissioningboard.nhs.uk/2012/11/09/ccg-bulletin-issue-23/). However, it is clear that the government is aware that GP commissioners won't understand many areas of health care and so CCGs are busy recruiting (often from the dying PCTs) officers who will do the commissioning for them. Indeed, within some regions, CCGs may contract/delegate commissioning work to a regional enterprise (which is essentially a business set up and run by previous PCT employees). We need to make sure that they do not just replicate the current system with its current failings, by commissioning services from the very NHS Trusts that have been failing women around the country.

AIMS is working with others to investigate what it may be able to do to influence change, but we would suggest that there are four things that you could be doing:

- Find out who the local GP commissioner is, ready for when action may be needed. The CCG managers may be good contacts, but this will vary by area, and local knowledge will be essential in finding out who are the people who can take action to enable real change.
- Find out about local consultations. There is a requirement to consult with local populations; so get in there and talk about maternity. Make sure that you go armed with at least one question to ask. The more you change the agenda to maternity the more you are likely to make sure it is on their plan.
- Be ready for the first CCG AGMs. These are an opportunity for CCGs to be held publicly to account. Again, be there armed with at least one question about maternity care in the area, remembering it is not so much about the answer that you get, but about the question that you have raised.
- Register with us as a local contact so that we can make sure that we have a network in place in order to take action. Please email campaigns@aims.org.uk

This Journal really highlights how much women value the personalised care that small, midwife-led units offer; and since that is also the care that is safest for mothers and babies, and the most cost-effective form of maternity care, there is no excuse for not offering it to all women. There will also be the additional benefit of freeing up obstetric time for those who really do need it, ensuring that they also get better and more personalised care. There is really nothing to lose.

Debbie Chippington Derrick and Ruth Weston

Bigger is not always better!

Sarah Davies and *Heather Rawlinson* discuss the experience of centralisation of maternity services in Greater Manchester

We write this article as midwives and mothers who were part of an eight-year campaign against the maternity unit closures and centralisation in Greater Manchester. Centralisation, also known as 'reconfiguration', is currently very popular in today's resource-starved NHS. Reconfiguration means the closure of units – which of course makes the remaining ones larger. These larger hospitals are then feted as 'Centres of Excellence' which provide supposedly better care and more choice for childbearing women. Six months after the last maternity unit closure, the centralisation of maternity services in Greater Manchester is being cited by the head of the Royal College of Obstetricians and Gynaecologists, and the head of the Royal College of Physicians, as a model to be emulated throughout the country.[1,2] But are the changes an improvement, and what do they mean for our maternity services?

Manchester's reconfiguration, dubbed 'Making it Better', is to date the largest in the UK. We now have eight consultant obstetric units instead of thirteen. The smaller consultant units which have been closed over the past four years are Trafford General maternity (January 2010; approximately 2,800 births per year); Rochdale maternity (June 2011; 3,000); Salford maternity and neonatal (November 2011; 3,500); and Bury maternity and neonatal (March 2012; 2;500). There are now larger maternity units at Wigan, Tameside, North Manchester, Oldham, Bolton, Wythenshawe, Stockport and Central Manchester. Central Manchester and Bolton will become amongst the largest hospitals in the country, with Central Manchester on track for 8,500 births a year. Although freestanding units were recommended as part of the plans, Manchester Primary Care Trusts (PCTs) showed no appetite for them and so none of the proposed birth centres at Trafford, Bury and Rochdale have gone ahead. Salford was able to retain a freestanding birth centre due to sustained local political pressure, but the service will be up for review in a year's time.

In the reconfiguration, staff have been uprooted from units where they have given many years of service, leaving friends and colleagues and moving to new posts. Many experienced staff have retired rather than face the upheaval; others have left the area. This has meant the loss of an important pool of experience and brings concerns about skill mix, as well as the amount of support available for newly qualified midwives. Change has affected all midwives, whether they transferred to a new unit or stayed in an existing one. Levels of midwifery autonomy differ from unit to unit, and everyone has had to develop new working practices and form new team relationships.

During our campaign against the closures we voiced concerns about capacity, safety and intervention rates. When the reconfiguration plans were first published, they were based on a far smaller number of births than we currently have and the new units have already had to be expanded well beyond what was anticipated. The birth rate has since continued to rise, faster than the rest of the country, and the units are extremely busy. Contrary to the 'spin' about poorer units warranting closure,[2] Salford Royal, which served one of the most deprived districts in the UK, was amongst the best-performing and was closed nonetheless.

We are concerned about the increased travel distances in a congested urban area which inevitably mean it takes longer to access services in labour or in an emergency. This of course has implications for both home and hospital births. Anecdotally it is reported that the number of babies born before they are attended by a midwife (BBA) has increased, as has the number of births occurring in Accident and Emergency units, although no official figures are available yet. We have concerns about safety in the community, due to the fragmentation of services. For example, Salford community has been divided between four different trusts and no longer exists as an entity for maternity care. This means four different policies for everything from safeguarding children to home birth.

From the monthly figures of local trusts, we know that intervention rates have risen. Salford Royal had the lowest caesarean section rate in Greater Manchester (17.6%) and now current rates are well over 20% in all trusts apart from Central Manchester. In Bolton the caesarean section rate in August 2012 was nearly 30%.

There is a medicalised culture in some of the larger units that was not there in the smaller ones (for example doctors doing 'labour ward rounds', when previously they would wait to be invited into the rooms). Many more women seem to be being diagnosed with risk factors. This phenomenon was also found in the recent Birthplace study, where almost 20% of women in the obstetric unit group had at least one complicating condition noted at the start of care in labour, compared with less than 7% in the other settings.[3] The increased intervention rates in the hospitals are likely to be a result of the reduced autonomy of midwives that is often seen in more medicalised units – for example midwives not feeling free to exercise their clinical judgement and being expected to adhere strictly to medical guidelines. Also the time pressures in busy units inevitably lead to a culture of intervention rather than 'watchful waiting'. One positive element is that labour ward staffing has improved, so that most labouring women receive one-to-one care from a midwife. However, the large postnatal wards have become exceedingly busy and women are discharged

home early. In addition, most Trusts are now contracted to provide only three postnatal visits which raises concerns about ongoing postnatal support and recognition of problems.

the picture is not all doom and gloom

But the picture is not all doom and gloom. Midwives are amazingly resourceful, and women continue to have babies! Bolton, St Mary's, Wythenshawe and Stockport all have 'co-located' birth centres which offer midwife-led care. Salford freestanding birth centre had 170 births in the first 10 months after opening and bookings are increasing rapidly. At North Manchester, the new co-located midwifery-led-unit (MLU) is proving to be very popular with both women and midwives. It opened in September 2011, became fully operational in December and had over 500 births in the first year. It is staffed by core staff and community midwives who are on call for the unit twice a month and also come in with 'their' women. Community midwives who already follow their women are exploring the feasibility of caseloading. In Stockport, a lead midwife has succeeded in leading change to make the co-located birth centre the 'default' option for women. Bolton has recently recruited a Consultant Midwife, which will help to address the issue of rising intervention in that Trust. (When the reconfiguration plans were first approved, a consultant midwife was promised for each Trust.)

The new alongside MLUs are great; the rooms are private, calm and comfortable, pools have sparkly lights, medical equipment is discreetly hidden, there are birth couches and double beds, and partners can stay after the birth. In the consultant units, use of pools, birth balls and birth couches is far less common, with the obstetric bed still dominating the room. Midwives and students are working to change this, as they know that every woman in labour, regardless of where she has decided to birth, should be enabled to be mobile, adopt upright positions and use a birth pool or bath. When services are organised into radically different spaces ('midwifery-led, relaxed and touchy-feely' seen as different and separate from 'obstetric-led, stark and high tech'), it can add to an 'us and them' culture, as also noted in the Birthplace study.[4] This 'us' and 'them' tribalism, which is apparent in several places, is not conducive to seamless care for women.

Power issues are always at the heart of reorganisations of maternity care. The planners justify their decisions by saying that clinicians were at the heart of the changes. This is true; but it is important to ask the question: who exactly were these clinicians, and what vested interests did they have? The main power players in Manchester's reconfiguration were neonatologists, and the supposed benefits were usually couched in terms of improvements in the care of sick and premature babies. Wider public health issues were never discussed. For example Anthony Emmerson, clinical lead for the Neonatal Network, was often quoted in the press saying that centralisation would *'help to save the lives of up to 30 more babies every year'*.[5] The evidence used to underpin this statement was questionable and has been challenged, and any purported benefits certainly should have been balanced against the possible harmful effects on women in labour having to travel further. Our campaign challenged the logic of herding large numbers of healthy women into centralised

The arguments about the cost effectiveness of larger units do not add up

St Mary's Birth Centre - The Aqua Room

St Mary's Birth Centre - The Rose Room

hospitals (and thus putting them at higher risk) for the supposed sake of a small number of extremely small preterm babies.

There is not a great deal of research evidence evaluating NHS reconfiguration, and none for maternity; but the Nuffield Trust has suggested that reconfiguration does not benefit patients and does not reduce costs either.[6] More recently a detailed review of outcomes has concluded that hospital mergers provide no advantages other than reducing admissions. The researchers found that waiting times and travel distances both rise, and suggested that the removal of capacity may reduce patient welfare.[7] A survey of women's views and experiences in Greater Manchester has been commissioned by the Maternity Network, but the results are not yet available.

The arguments about the cost effectiveness of larger units do not add up. The overall cost of the 11 year project in Greater Manchester has not been revealed, though according to the Children, Young People and Families' NHS Network, commissioners have already made recurrent investments of an additional £10m a year on staff and skills maintenance, and will spend £29m over the life of the project.[8] We know that Greater Manchester commissioners agreed a three-year 'transitional top-up' for births of £110 for each birth, and given the greater than expected rise in the birth rate, in the current economic climate this will put further pressure on Trusts' finances. It is now clear from the Birthplace study and others[3] that midwifery-led care is less costly than obstetric-led care, but despite this there does not seem to be any plan to expand community midwifery numbers.

According to guidelines from the Royal College of Obstetricians and Gynaecologists,[9] all units with 6,000 or more births a year should have at least a 60-hour consultant presence (p50). So although the majority of women giving birth in the large units are healthy and simply require midwifery care with obstetric back-up, the number of obstetric consultants has been increased. Obstetric care is, of course, essential; but it should be focused on those women who require it. The impression we are left with in Greater Manchester is that obstetric and neonatal empires have increased, while community-based care is under increasing pressure. We are concerned that the fragmentation of care will adversely affect women and families, especially the more vulnerable.[10]

In conclusion, the picture in Greater Manchester today is of an over-medicalised, over stretched, centralised service within which there are pockets of excellent midwifery-led care. Now all parties urgently need to work on ensuring that every woman is aware of her options for birth, empowered to make an informed decision about the care she wants, and able to access that service. The concepts of 'choice' (or autonomy) and control in birth are enshrined in government policy, and must be considered, not as luxuries, but as a woman's basic human right.

Sarah Davies and Heather Rawlinson

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Comments on Saint Mary's Birth Centre

Comments from mums

'Staff very accommodating, could not do enough! I've already recommended it to friends – a lot less clinical and more relaxed.' Estelle

'Couldn't have wished for a more enjoyable and safe birthing experience.' Jenna

'The facilities are good, staff brilliant – a great experience and very relaxing.' Vicky

'Staff were fantastic, can't thank them enough. I was really anxious about birth but my care from start to finish was outstanding.' Ashley

'Very comforting, soothing and calming, it made me feel at ease compared with my other births. Very professional staff but at the same time friendly and reassuring.' Donna

'Homely and clean, staff amazing, would definitely come again.' Angela

Comments from midwives

'Providing midwife-led care on the birth centre has given me the opportunity to develop skills in autonomous practice, and increased my confidence in my own skills and the process of normal birth.'

'I have gained real job satisfaction by providing women-centred care and caring for women throughout labour up until discharge home.'

'I feel extremely grateful to have had the privilege of practising true midwifery in a positive environment that is conducive to normal birth.'

'Practising in a stand-alone birth centre has allowed me to reclaim autonomy, promote normality and further empower women and myself!'

Salford's 'new from old' service

Alison Richardson introduces Saint Mary's Birth Centre

Salford in the North West of England has a long history of providing a midwife-led service for women. The maternity unit was opened in 1966 and incorporated a 4-bed 'GP unit'. This unit was staffed by community midwives who provided care in labour for low-risk, healthy, multiparous women, who were then discharged home after six hours. There were approximately 250 births per year in this co-located unit.

Over the next four decades the service changed in many ways: General Practitioners became less involved in the care of labouring women, its name was changed to the Birth Centre, women having their first baby were 'allowed' to birth here too and the number of births increased to 665 by 2010.

Sadly, Salford's in-patient maternity services ended in November 2011 as part of the Greater Manchester 'Making it Better' reconfiguration programme. However, it had been agreed to set up a new stand-alone birth centre on the Salford Royal site, to be managed by the Central Manchester Foundation Trust (CMFT).

The Salford midwives were used to working autonomously in the co-located birth centre and many chose to continue working in the new stand-alone unit. We were further encouraged by the Birthplace study[1] which found that free-standing birth centres were safer for babies and safer for women than hospital births, with fewer interventions and therefore less morbidity.

more like a bedroom than a hospital room

Following the closure of Salford's maternity unit, there were two weeks of refurbishment which included the fitting of a new birth pool. The six rooms, three of which are en-suite, were given a more calm, relaxed, homely ambience, with each one named after a plant with calming, soothing properties rather than a number. The colour of the plant is incorporated into the colour scheme of the room with co-ordinating birth ball, recliner, mats and bean bag. All rooms have tea and coffee making facilities and women are encouraged to eat and drink throughout labour. All equipment is kept in a cupboard so it is not on display to the women, which makes the room more like a bedroom than a hospital room. Women are free to choose their room and are encouraged to make it 'theirs' for the duration of their stay. They may have who they want to accompany them in labour, one person may stay overnight with them if they wish and there are no restrictions on visiting. Women may go home as soon as possible after giving birth, or remain overnight if they prefer. 100% of women who have birthed here would recommend it, and described the room and facilities as homely, excellent, relaxing and clean. Fast, painful, fantastic, relaxed and calm were words used to explain their experience of birth.

our statistics show that using water and remaining mobile reduce the need for drugs

The Saint Mary's Birth Centre in Salford opened on 5 December 2011 and with over 100 wonderful births so far, we are 'on target' for the anticipated 200 births per year. The centre is staffed 24 hours a day by core and community staff who are committed to providing a safe, relaxed, calm environment with a homely atmosphere within which they are able to give excellent, evidence-based one-to-one care. This is possible as there is at least one midwife and one support worker on each shift, with another midwife called when a birth is imminent. 98% of women describe the staff as friendly, approachable, reassuring, helpful, professional and calming. The midwives have the experience and confidence to support women in their choices and most have attended Neonatal Life Support and Examination of the Newborn courses. Staff encourage women to use water, remain mobile and adopt whatever position is comfortable for labour and birth. Analgesia is given if women ask for it, although our statistics show that using water and remaining mobile reduce the need for drugs. 75% of women choose to use water in labour, with 52% having pool births. Midwives working in our birth centre feel it enables them to empower women and helps them to feel empowered themselves.

Progress of the new birth centre is closely monitored by Central Manchester Foundation Trust, supervisors of midwives, the North West Network, the 'Making it Better' team, the Salford Maternity Services Liaison Committee, midwives and, of course, the women who use our service. The birth centre was initially commissioned for two years, but it is hoped that its success will allow it to continue providing an excellent alternative choice to birthing at home, or in hospital, for women.

Alison Richardson
Team Leader

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Blackburn Birth Centre

Suzanne Unsworth and *Caroline Broome* share a vision for the future

In line with government policy,[1,2] East Lancashire consolidated its maternity services and Lancashire Women's and Newborn Centre (LWNC) opened in Burnley in November 2010. As part of this reconfiguration, three birth centres opened across the East Lancashire Maternity Service.

The Blackburn site was previously used as a health facility and was in danger of becoming derelict. After a £900,000 face-lift the Blackburn Birth Centre was ready to open in September 2010.

As of November 2012, more than 2,000 babies have been born at the centre and it is well on its way to being declared a huge success.

Blackburn is an area of significant social deprivation currently ranking 17th in the country. It is a multicultural community where significant proportions of the residents are of Asian heritage. Both birth and death rates are above the national average.[3] The location of the birth centre was crucial in order to serve the community it was intended for. It is central, easily accessed from all the surrounding areas and is alongside the M65 'corridor'.

For the first two months, the birth centre operated using a team of midwives who had all expressed a passion and belief for working in a free-standing birth centre, and a clear philosophy was developed.

Once the final stage of the reconfiguration was complete, an integrated community model was developed. Midwives in the community undertake a mix of shifts in the birth centre and in the community. This means that midwives are skilled in all areas, promoting continuity and enabling women locally to make choices. This includes working at the consultant-led unit at the Lancashire Women's and Newborn Centre in Burnley when the birth centre experiences low activity or when women require transfer. Conversely, midwives from the consultant unit work at the birth centre during busy periods to ensure that the place of birth for women is respected. This model offers seamless care for women, with a strong emphasis on collaborative working across East Lancashire Maternity Services.

The birth centre stands in beautiful gardens, sharing parking access with the East Lancashire Hospice. It is a single storey building with four birth rooms. There are three pools and a large four-bedded postnatal area. Each room has a patio with outside furniture where women can move through their labour at their own pace, surrounded by family, friends and very supportive midwives. It is clean and contemporary with a calm, relaxed atmosphere, often compared to a Spa!

Reflecting on the last eighteen months it is important to understand why Blackburn Birth Centre is proving to be so successful. There is growing evidence to suggest that low-risk women benefit from midwifery led care and few would dispute there is no risk-based justification for requiring the birth of all women in hospital.[4] So why is it that so many midwifery led units and birth centres are under threat? In a recent address to the King's Fund, Cathy Warwick (the then President of the RCM) put the blame with the clinicians, stating that variation in practice is due not to the women but to midwives' reluctance to embrace flexible working practices and to positively promote their service.

'The midwives made it so easy for me. Giving birth at the Blackburn Birth Centre was a fantastic experience and it went exactly how we had planned. I would recommend it to everyone.'

Penny, mother

Historically, Blackburn had already adopted a model of integrated midwifery whereby midwives worked both in the community and in the local district general hospital. Philosophies of flexible, skilled working practices were already embodied within the previous model of maternity care and were easily transferable.

The birth centre is managed by two band 7 midwives, who oversee three teams of band 5 and 6 midwives, health care assistants and clerical support. The careful planning of rotas ensures that junior midwives are always supported by more experienced staff. The birth centre welcomes student midwives, medical students and students from out of area on elective placements. All newly qualified midwives spend six months at the birth centre as part of their preceptorship programme.

This inclusivity ensures that the birth centre is seen as part of mainstream services and maintains healthy relationships between the different sites. The support of the obstetricians and neonatologists is invaluable, offering excellent examples of good collaboration. There is a lead neonatologist with whom the midwives regularly discuss practical issues. Excellent communication and a strong ethos of mutual respect have been essential to the safe care of women and their babies. They are crucial for the maintenance of trust and the smooth transfer of care to the consultant unit when appropriate.

'I find that working at the birth centre at Blackburn with women and their families is extremely rewarding. Here I can give one-to-one care and support and preserve normal birth.'

Gwen, midwife

Strong effective leadership is vital in order to maintain the philosophy and ensure consistency of women-centred care. The managers have been instrumental in supporting the midwives in the transition into their new role. It is impossible to meet the challenges of a birth centre without the midwives themselves feeling supported and able to discuss the fears and anxieties sometimes associated with a free-standing birth centre. Developing self-belief and a vision has been crucial. The midwives often discuss how the night skies should be lit with neon *'BC'*s and not fast food outlet signs!

Central to the birth centre at Blackburn is the preservation of individual choice, dignity and privacy. We believe that every birth matters and the way a woman gives birth has an impact on the rest of her life. Research shows that women want care based upon trust, care and mutual respect.[5]

The Blackburn Birth Centre provides a calm, relaxed birth environment with one-to-one care. The women are not restricted in the number of birth partners and this allows family members to support each other and in turn offer better support to the woman. 60% of the women labour in the pool and 40% give birth in the water. Women are encouraged to eat and drink in labour. There are birthing balls, mats and a birthing stool. Few women choose to give birth on the bed, opting for an active birth with themselves at the centre of their care.

'I had a really pleasant experience at the Blackburn Birth Centre. All the midwives are very friendly and helpful.'

Neelam, mother

Midwives working at the birth centre also meet women at their booking appointment in the community and discuss place of birth at this point. The decision is revisited at various intervals during the antenatal period. This exposure to the staff of the birth centre, with the opportunity for women to come to the centre for antenatal appointments, membrane sweeps, antenatal information sessions etc., means that it is a familiar place to the women and therefore seems a natural place to

give birth. This flexible approach facilitates the opportunity for women to choose their place of birth and to change their mind at any point in their pregnancy. It also ensures that the birth centre remains central within the community.

Each week a Supervisor of Midwives runs a session to enable women who do not conventionally fit the criteria to birth at a free-standing birth centre, but wish to exercise this choice, to discuss their care. Choice is respected and care plans devised on an individual basis, often in conjunction with the obstetric and neonatal team and, of course, the woman and her family. This has proved highly successful with women, families and midwives.

There are, without doubt, challenges to face in the future. Increasingly, women are being led to believe that birth is an event to be feared and is a 'dangerous' process. However, midwives working in a supportive environment play a key role in normalising the processes of birth and inspiring women and their families on their wonderful journey in to parenthood. At Blackburn Birth Centre, midwives have been in the privileged position of watching, quietly and respectfully, a woman transition into motherhood, not fearful but in eager anticipation.

Suzanne Unsworth and Caroline Broome
Blackburn Midwives

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Different parents, different needs

Alex Smith looks at meeting diverse needs in an antenatal class

Within every antenatal class there is a glorious complexity of contradictory needs. This article begins to question whether group instruction may undermine individual autonomy.

If we think of our work as an educational intervention, one solution to the problem of different needs is to apply a routine package of care to everybody – a little bit of everything – a sort of mass, multi-target immunisation programme. As reflective practitioners, there are two important questions to ask as we plan and evaluate. Is this approach effective? And does it 'do no harm'?

Evaluation is how we measure whether or not we are reaching our aim – the optimal wellbeing of the new family. Most women we meet would prefer a straightforward birth experience and, under the right conditions, we know this is usually attainable, invariably enriching and has a life-long positive effect on the woman and her baby, and, therefore, on the whole family. Another factor that has a long-term positive effect is the degree to which the woman felt in control, that she was the heroine of her own journey. Despite our very best intentions, and reflecting our own observation, there is little evidence that our one-size-fits-all intervention increases the incidence of either of these things. Yet, somehow, we have a very good sense that we are meeting our learning outcomes. This may mean one of three things:

- Our aims are unrealistic
- Our learning outcomes are not those required to meet our aims
- Our learning outcomes have a positive effect for some, which is cancelled out by a negative effect on others – that they may occasionally do harm.

The first of these is unthinkable. We know that women, individually and collectively, hold the power they need to enjoy the best possible journey into motherhood. Our aim is realistic.

The second requires a Socratic ability to question our own assumptions. Like any other routine intervention – ultrasound scanning, induction, electronic fetal monitoring, hospital birth – the good intention and apparent logic upon which it is based does not necessarily make it right.

The third explanation is supported by anecdotal accounts of parents being disturbed and even frightened by their NCT classes. Newton's third law of motion states that, 'for every action there is an equal and opposite reaction'. If our intervention moves one person toward their goal, then it may move someone else away – a sort of Karmic counterbalance for our force of will. 'If our 'medicine' is powerful enough to have a good effect on one person, then it may also have a bad effect on another, or at least cause uncomfortable side-effects that make that person reluctant to 'swallow' everything they hear. In philosophy and ethics, this dilemma is understood as the Doctrine of Double Effect. Teachers who sense this tension may seek to resolve it by watering down the medicine to the point where it does little harm, but also little good.

Reframing the problem of different needs in terms of the routine use of intervention enables a dialectic resolution to our dilemma – for the physicists among you, a string theory unification of apparently incompatible forces that will open up new dimensions for us as antenatal teachers. One new dimension is to embrace the concept of monitors and blunters. Anticipating a perceived threat, monitors cope by seeking information, and blunters cope by avoiding it. Monitors want to know the risks and benefits of medical forms of pain; blunters would rather focus on breathing skills, positive affirmation and visualisation. Monitors tend to be more anxious and less able to manage pain; blunters are not in denial, they simply have another way of managing uncertainty.

Although the concept is controversial, people immediately identify with the idea. Studies show that monitors and blunters benefit from receiving information tailored to their coping style. Monitors who receive too little information will use Google; blunters who receive too much information cannot remove unwanted ideas and pictures from their head and have a poorer experience as a result. After the course, it is easier for the monitors to feedback that more information on caesareans would have been good, than it is for the blunters to admit that the caesarean role play was frightening, and this may mislead us when it comes to evaluation.

Returning to the immunisation analogy, we know that the most important factors in protecting a person's health are not the injections of medicine, but good nutrition and improved living conditions, in the widest holistic sense. Similarly, in our classes, there are many gentle non-graphic ways of promoting wellbeing that will be useful for monitors and blunters alike, no matter how each journey unfolds. Exploring philosophies and strategies for the concept of 'living with uncertainty', for example, enables learning that can be interpreted and applied by each individual according to individual need. Each person's journey into parenthood is unique, it is not a package cruise. By removing that long list of 'what ifs' from the agenda, we can offer individually tailored information – different flavoured doses of Mary Poppins medicine – using our intervention more elegantly, and even more effectively.

Alex Smith

For further reading on this subject please visit the AIMS website, www.aims.org.uk. If you would like to tell us how your antenatal education, or lack of it, affected your birth, please email editor@AIMS.org.uk.

Making choices

Beverley Beech highlights some key issues

In the United Kingdom women have the legal right to birth at home if they so choose. This is protected by Article 8 of the European Convention on Human Rights.

'In countries and areas where it is possible to establish a home birth service backed up by a modern hospital system, all low risk pregnant women should be offered the possibility of considering a planned home birth and should be informed about the quality of the available evidence to guide their choice.' Olsen & Jewell 1998

In 2006 the Nursing and Midwifery Council published further advice to midwives which made it clear that *'Should a conflict arise between service provision and a woman's choice for place of birth, a midwife has a duty of care to attend her'.*

Despite the NMC advice to midwives, it is clear from those who contact AIMS that women are commonly still vigorously dissuaded from birthing at home. There is a common belief that anyone deciding to birth at home has to obtain the consent of an obstetrician or senior midwife. This is untrue, as a woman has the right to decide where she gives birth and a midwife has a responsibility to attend. If she is unable to do so, she is required by her Midwifery Rules to seek support from her Supervisor of Midwives and arrange for another midwife to attend.

It is common for women to be told that the home birth service has been cancelled, suspended or scaled back due to staff shortages and that, in the event no midwife is available, women have no choice but to go to hospital. In reality women who stand their ground and insist on remaining at home are likely to get care, although some Trusts have threatened to send an ambulance, and only sent a midwife when the woman made it very clear she would not get in it.

When a woman states she wishes to stay at home regardless, or plans not to call for a midwife, it is common for her to be told that a home birth without a midwife is illegal, either because the midwife or doctor is ignorant of what the Nursing and Midwifery Order 2001 actually says or because it is the easiest way of gaining compliance. The Order, Part 9 Article 44, actually states that it *'is illegal for an unqualified person to undertake the role of a registered midwife.'* Article 45 further explains that *'no person other than a registered midwife or a registered medical practitioner shall attend a woman in childbirth (assume responsibility) unless in an emergency or in supported recognised training.* It goes on: *'An unqualified person is an individual who gives medical or midwifery care but may not lawfully do so.'* This does not mean that a midwife or doctor must be present, it means that you can't work as one when you are not registered. It does not prevent a woman either birthing on her own or birthing with her husband, partner, other relative or friend present, but they *'must not assume responsibility, assist or assume the role of the medical practitioner or registered midwife or give midwifery or medical care in childbirth.'* Sometimes women, choose to telephone for a midwife at the last minute, thereby increasing their chances of giving birth before a midwife arrives.

Women who want a home birth are often accused of being selfish and of putting their babies at risk, without any evidence to support these claims. Research evidence indicates that the health outcomes of planned home birth, such as Apgar scores or need for resuscitation, are as good as or better than those for hospital birth, and that many women experience a range of emotional and practical benefits from giving birth at home.

It was commonly accepted that birth in hospital was safer than home birth until Marjorie Tew published her analysis of the risks of home birth in 1977. This analysis has never been refuted and further research continues to support her findings.

'There is ample evidence that planning a home birth improves overall outcomes for mothers and babies … For women with normal pregnancies labouring at home increases the chances of a birth that is both satisfying and safe.' Royal College of Midwives 2002

The iatrogenic risks of birth are still poorly researched and the risks of hospital deliveries are underplayed. However, it should be noted that the 2004 Confidential Enquiry into Maternal and Child Health stated that *'suicide was in fact the leading cause of Indirect or Late Indirect maternal death over the whole year following delivery.'* This might even be more likely after a hospital birth, as medical interventions and a lack of personalised care and support are known to increase psychological trauma.

It is important to understand differences between the government's, obstetricians' and paediatricians', and mothers' definitions, and assessments, of 'risk'. Often officials and doctors see it as having facilities and staff available immediately to deal with emergencies, or intervening in a situation that might become an emergency. Provided the mother takes home a live baby they are not concerned about, or even aware of, the mental and physical damage that may have been done in the process. Mothers include the whole family outcome – their mental health, bonding with the baby, bonding of the father with mother and baby, bonding of siblings, and their postnatal physical state (stitches, infection, postnatal depression, post traumatic stress). It is not just about health of the child, but the creation of a family, with a mother who has the ability to care for them and joy in doing it. The accounts of women who have experienced both kinds of birth have convinced many doubters.

'Over the last 50 years of medicalised, centralised birth, women's hopes and desires have been remarkably consistent. They want to come through the experience physically and mentally whole and in a fit state to start life as a parent with a live and healthy baby. Parents who will not benefit from medical intervention have been misled into believing that the best way to achieve their hopes for the birth is by an operative or obstetric delivery. As a result, the medical resources of the health service are spread thinly across too many births and poor care may be provided both for those who only need non-medical support to have a normal birth and for the minority who need medical intervention to preserve the life or well-being of mother and baby.' Beech & Phipps 2008

Beverley Lawrence Beech

There are several articles on the right to home birth and the reasons women are denied choice on our website, www.aims.org.uk. Please share your experiences with us.

Delaying the clampers

Amanda Burleigh explains the call to change NICE guidance on cord clamping

Approximately 50 years ago oxytocic drugs were introduced to labouring women with the intention of shortening the third stage of labour, preventing postpartum haemorrhage and improving the mortality rate. The function of the umbilical cord was not even considered, never mind researched, and immediate clamping and cutting became standard practice, often occurring before the baby had taken its first breath.

Both Aristotle and Darwin observed the process and warned against early clamping of the cord. Yet premature cord clamping is still widely practised in many UK and world hospitals today.

'Frequently the child appears to be born dead, when it is feeble and when, before the tying of the cord, a flux of blood occurs into the cord and adjacent parts. Some nurses who have already acquired skill squeeze [the blood[back out of the cord [into the child's body] and at once the baby, who had previously been as if drained of blood, comes to life again.'

Aristotle 300BC

'Another thing very injurious to the child, is the tying and cutting of the navel string too soon; which should always be left till the child has not only repeatedly breathed but till all pulsation in the cord ceases. As otherwise the child is much weaker than it ought to be, a portion of the blood being left in the placenta.'

Erasmus Darwin, Zoonomia, 1801

In response to growing maternal requests for delaying cord clamping and the mounting evidence of the benefits leading to evolving personal opinion, in November 2012 the Royal College of Midwives (RCM) released new evidence based guidelines for the third stage of labour.[1]

The World Health Organisation (WHO), UNICEF, International Confederation of Midwives (ICM), Royal College of Obstetricians and Gynaecologists (RCOG), International Liaison Committee on Resuscitation (ILCOR) and International Federation of Gynecology and Obstetrics (FIGO) all support delayed cord clamping. NICE (National Institute of Clinical Excellence) is looking to change their guidelines but not until November 2014, still two years away.

Benefits of delayed cord clamping

Immediately after birth the cord pulsates as the placenta continues to provide essential oxygen and nutrients, and delivers blood back to the baby. This is known as placental transfusion and is a vital part of the birth process. As long as the cord is pulsating the risk of haemorrhaging from the uterus is minimal as the placenta is still attached.

Dr Judith Mercer, a leading expert on cord clamping, has produced an extensive amount of evidence regarding the benefits of delaying clamping for both full-term and very preterm infants.[2,3] With colleagues, her review of the available literature showed that delaying cord clamping produced higher blood pressure, higher haematocrit levels, more optimal oxygen transport and higher red blood cell flow to vital organs, reduced infant anaemia and increased duration of breastfeeding. For very preterm infants, the benefits also included fewer days on oxygen and ventilation, fewer transfusions, and lower rates of intraventricular haemorrhage and late-onset sepsis.

Other research has shown that immediate cord clamping deprives the baby of up to 40% of its intended blood volume. Research shows that leaving the cord intact leads to a weight gain of up to 210g in the five minutes following birth.[4] The blood that the baby is deprived of contains stem cells, blood cells and other natural hormones intended to complete the birth process.

Immediate cord clamping is a major risk factor for anaemia in newborns. Research studies have shown that immediate cord clamping leads to long-term anaemia which impedes learning and development.[5,6]

The guidelines

The new RCM guidelines recommend that midwives should be competent in both active and physiological management of the third stage of labour. However, after decades of active management, midwives need to develop competency and confidence in physiological management. This is important because (and my experience reflects this) when physiological management is offered to women as a reasonable option, many will choose it.[7] Physiological management can be seen as the logical ending to a normal physiological labour.[8,9]

Women at low risk of postpartum haemorrhage who request physiological management of the third stage should be supported in their choice.[10]

Active management involves giving a prophylactic uterotonic, cord clamping and controlled cord traction.

Physiological management, where the cord naturally clamps itself, involves no administration of drugs to contract the uterus and no clamping or cutting the cord until the placenta is delivered. It also includes promoting the use of gravity to assist delivery of the placenta in a timely manner with maternal effort.

The guidelines recommend that if physiological management is attempted but intervention is subsequently required, then management must proceed actively. If the placenta is retained after one hour, active management should be considered, but of course women still have the choice.

The Cochrane review exploring the effect of timing of umbilical cord clamping showed both benefits and harms for late cord clamping.[11] Immediate cord clamping was

associated with reduced placental transfusion and lowered infant haemoglobin. Following delayed clamping there was a significant increase in infants needing phototherapy for jaundice accompanied by an increase in infant haemoglobin levels and serum ferritin levels in the first few months of life. In response to this evidence, guideline recommendations have been amended to include delaying cord clamping. The timing of cord clamping needs to be determined in the clinical context. It is estimated that this normally would be around three minutes. RCOG simply concluded there was a need for large trials in this area.

there is significant evidence to suggest that active management does have an iatrogenic effect

More importantly, perhaps, for low-risk women who can accommodate the increased blood loss, there is significant evidence to suggest that active management does have an iatrogenic effect, whereas doing nothing does not.[2] Routine active management with the specific aim of reducing blood loss is questionable in countries where women enjoy good health and nutrition.[8] This challenges the appropriateness of practice that responds to statistically significant outcomes rather than to clinically significant outcomes.

Incorporating skin to skin contact, early breastfeeding and upright posture may also expedite expulsion of the placenta and reduce the length of the third stage and, subsequently, the amount of blood loss. Sharing such information with women will allow them to make an informed choice.

WHO recommends[12] that in newly-born term or preterm babies who do not require positive-pressure ventilation, the cord should not be clamped earlier than one minute after birth, based on a decrease in the need for blood transfusion, an increase in body iron stores and very low quality evidence for risk of receiving phototherapy for hyperbilirubinemia. This should be understood as the lower limit supported by published evidence.[2]

Personally, I wish the guidelines had been a bit stronger and clearer about best practice. WHO issued stronger guidelines outlining the benefits of delaying cord clamping; however, the RCM guidelines imply that there is less clear evidence either way, leaving it still open to individual practice in the UK. Better guidance for practitioners is needed, and not only for midwives supporting normal birth, but for obstetric and neonatal staff who are involved in more complex births.

In the UK, as a member of a growing global network, I have started a petition as a method of trying to persuade NICE to bring forward the review date and recognise the necessity of ensuring that optimal cord clamping is included in the guidance as best practice. If we can convince NICE to change the guidelines earlier, this may encourage other organisations worldwide to implement delayed cord clamping as well as making a difference to the one-and-a-half-million children who will be born in the UK between now and the review date.

NICE's initial response to the delay in issuing new guidance is that informed choice is, and should be, practised. However, we know that the majority of births are actively managed and women do not get informed choice. In addition, many midwives, after decades of performing active management, need to gain skill and confidence in managing a physiological third stage of labour and many UK doctors will simply not proceed to implement change unless they have written guidance.

Amanda Burleigh
Midwife and Researcher

The link to the petition can be found here:
www.change.org/petitions/nice-implement-delayed-cord-clamping-immediately
The RCM guidelines can be downloaded here:
www.rcm.org.uk/college/policy-practice/guidelines/practice-guidelines/

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Childbirth as entertainment

Gill Boden asks whether the current trend for televising birth is more appropriately titled birthporn

Recently Britain has been entertained by two very different genres of TV entertainment, both centrally featuring and depicting childbirth. One, the brutally realistic (but nevertheless heavily edited) account of daily life in a maternity unit, *One Born Every Minute*; the other, the heart-warming and unashamedly sentimental tale of East End midwives in 1950s Britain, *Call the Midwife*.

While these programmes are very different, they have features in common. One crucial point is that, in both cases, the camera follows women into the birthing room and, while stopping just short of pointing the camera between a woman's legs to witness the birth of a new human being through the woman's vagina, the viewer or voyeur is shown women naked or half clothed in the throes of childbirth, with the sights and sounds of agony or ecstasy as she births her baby on camera. This is a sight which, understandably, most of us find fascinating, particularly women who anticipate childbirth and are curious or frightened. There are also those who are horrified; for some of these, their own births have been badly managed and caused trauma, both physical and psychological, and so they find depictions of other women's suffering painful; others who were lucky enough to have joyous and empowering births but are angered and upset to see an experience that might have been life-changing and ecstatic for them become one in which birth and women's pain are trivialised as prime time viewing while people eat their tea. I have summoned up the metaphor of pornography here. It's a strong and emotive word but seeing people in the act of sex is generally not thought to be suitable TV viewing. I would guess that most men do not want to see erect penises while viewing with their families. By the same token, many women feel that the act of giving birth is the most private of all acts; they are at their most vulnerable and exposed.

many women feel that the act of giving birth is the most private of all acts

Where these two depictions differ is that one is the latest fictionalised account of childbirth, although based on the memoirs of midwife Jennifer Worth, and the other is a fly-on-the-wall documentary. In the documentary, cameras are wall-mounted in the labour room and midwives reportedly forget their presence; we can only suppose that women in the throes of labour are also likely to forget, so that even though at some stage they will have given consent (even if not fully informed), a gross intrusion of privacy happens each time a woman is filmed and the edited result is shown to millions of people.

health professionals believe they have the right to enter birthing rooms unrestrictedly

We should remind ourselves that until the 1960s most fathers would not have witnessed their own baby's birth. In Britain most babies were born at home, in a private space, where only invited people were permitted to enter. There has been, and still is, a tradition in most of the world that men should not enter that space but should wait outside until their baby is born or they are invited to enter; women have the company of chosen female kin and a midwife through their labour and birth. Hospital birth changed that: birth in hospital is almost inevitably public in the sense that health professionals believe they have the right to enter birthing rooms unrestrictedly, and in my experience a woman who demands privacy or requests to be attended only by women in a hospital birth is often regarded by staff with amusement or irritation.

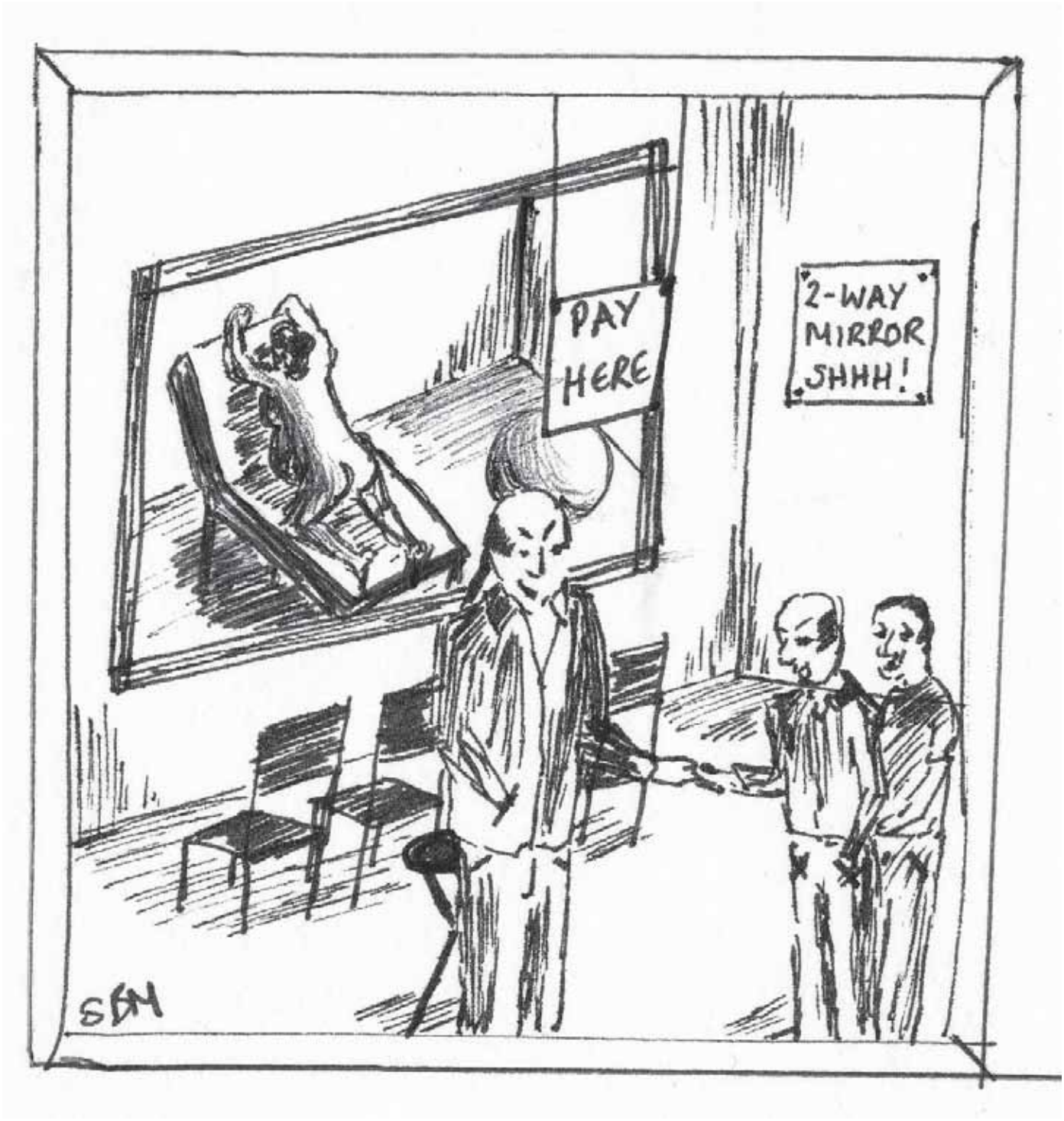
AIMS played its part in the campaign to allow fathers into labour wards. This happened because women needed a champion to protect them at their most vulnerable as they were shouted at and in some cases assaulted. However, this has been a mixed blessing. One major advantage of home birth is that the father can play a crucial role in protecting his partner from intrusion and allow her the privacy she may need to birth in peace and can judge sensitively when to be present. We now have the evidence for what midwives and women have known, which is that the birth process is triggered and orchestrated by hormones in the woman's and baby's body; a process which is easily disturbed and works best in conditions of warmth, semi-dark and privacy, not conditions that many hospitals can supply. We know that oxytocin is a main agent of childbirth and the hormone of love and sex, and that stress hormones seriously disrupt the process, as they are supposed to. The presence of strangers and interruptions slow down labour; it is not hard to imagine that cameras inhibit oxytocin production and increase production of stress hormones.

Call the Midwife has many positive features: it portrays women as independent agents who are brave and strong, midwives who are independent in their professionalism and respectful of the women in their care, and continuity of care and home births as the norm. It is arguably creating a demand for these in its eight million viewers.

One Born Every Minute, however, shows women who have no voice, who enter an institution and leave their autonomy at the door, who, in many cases, accept the inferior care they are often offered. Equally damaging is the view of midwives who seem to be uncaring, cannot deliver one-to-one care in labour and often behave unprofessionally. In their own interests midwives should be very wary of cooperating with documentaries of this kind.

I would like to see a campaign mounted to ask the RCM to instruct midwives to protect the privacy of birth against commercial interests of any kind. Women need to rely on midwives and trust that their priority will be the wellbeing of mother and baby: they should not be distracted by the demands of television. It was a sad day for midwifery when TV cameras were allowed into a birth.

Gill Boden



Pain in labour

Marie J Taylor reports on Nicky Leap's presentation – September 2012, Bristol

Professor Nicky Leap presented to a dedicated audience of birth supporters back in September 2012 at the Bristol Aquarium. She shared her research findings and wisdom regarding the approaches to pain in labour.

This sell-out event, at a great venue in central Bristol, gave those who attended a deeper understanding of why pain in labour is such an important topic, and equipped us all with practical tools we could use immediately. For those interested in gaining a deeper understanding Nicky provided signposts to further investigation. This review is a reminder for those who attended and provides people who weren't lucky enough to be there with the benefit of her sage words and advice.

The keystone to Nicky's presentation was the interplay between four elements around the approaches taken to labour pain and their impact on a triumphant and empowering birth. Her presentation was followed up by a fun and innovative 'speed dating' session where birthworkers got the opportunity to meet each other and discuss video clips of postnatal interviews with women and also midwives sharing their experiences.

Nicky showed us how mother's and caregiver's perspective (and subsequent choices they make throughout a labour) depend on who you are and what your role is at the birth. This then impacts the pain relief methods you are likely to use, which affects expectations, which dictates your perspective and so it goes on – see image below.

The pain associated with giving birth is often regarded as something to be avoided altogether, or at the very least endured. Examine the idea of pain further and Nicky Leap suggests the experience of it is based not just on anatomy and physiology but on what's going on in the mind and wider culture. Her presentation reminded me, as someone who supports people giving birth, about the impact and the limits that our own beliefs have on the expectations of the people who we want to experience a triumphant birth.

women's level of satisfaction with their birth experience does not correlate with the pain relief they receive

Nicky showed evidence that women's level of satisfaction with their birth experience does not correlate with the pain relief they receive. In fact, as a rite of passage, the existence of pain is important as it mostly marks memories in a positive way, building self esteem because women feel proud that they have coped and been self sufficient.

Nicky talked about taking an approach that works with pain, in contrast to a menu of pain relief. In my view the power of this is so great because of the subconscious expectations that are implied by the choice of approach.

Nicky Leap's 'Working With Pain' Framework

- Women CAN cope with the pain of uncomplicated labour
- Concept of *normal* and *abnormal* pain: the need for pain relief is associated with malposition/distocia
- Pain as a stimulator of endogenous opiods, minimising disturbance
- Pain gives a clue to progress

Nicky also addressed the issue of expectations of the mother and the caregivers. Many of us groaned when she highlighted research explaining the common expectations of intervention by obstetricians for their own births, but then I span off in a giddy haze when Nicky followed it up by stressing the importance of the power of persuasion and, more importantly for me, paying attention to what we can learn from fields of NLP (neuro-linguistic programming) and hypnosis (my areas of expertise) to persuade of mothers to trust their ability to birth and change their expectations. The most powerful tool is what she calls the 'Midwifery Wave'.

Midwifery Wave

It starts slowly

It builds to a peak

It starts to die down

It lasts about a minute

And then there's a REST

If only we had a video of the entire room doing the Midwifery Wave as they set it to memory! The concept that it lasts just a minute and then there is a rest frames the undefined 'contractions' into a concept that is achievable for the mother because it has a time frame and also there is time to rest and gather resources.

Another practical application of this that Nicky gave was to suggest things to say that alter perception and expectation.

Things to say that shift perception and expectation

- Your body will tell you what to do
- Trust your body
- Each contraction brings you one step closer to meeting your baby
- Between each contraction you can have a rest
- The uterus is the strongest working muscle in the human body – it's a wonderful, powerful organ
- You will find an inner strength that you didn't know you had

Her last suggestion, '*Many women find that. . .*', I thought was particularly powerful as it persuades the mother to 'try on' a different perspective to see if it feels right for her without forcing your point of view. However, we'll never really know what its like for another person, so Nicky advises that it should be used with caution.

Marie J Taylor

As this was such a successful event, organiser and AIMS committee member Chloe Bayfield will be organising more talks throughout the UK. Please contact her if you are interested in hosting a talk or speaking or if you have any subject suggestions. Contact her at chloe.bayfield@aims.org.uk or visit www.aims.org.uk.

Employ more midwives

National Federation of Women's Institutes AGM – September 2012, London

I was somewhat surprised to receive a phone call from AIMS committee member, Debbie Chippington Derrick, asking me if I was able to attend the AGM of the National Federation of Women's Institutes on behalf of AIMS. My mind flashed to my only experience of an NFWI AGM – scenes from the film *Calendar Girls* – and wondered what might be required of me!

It turned out that the NFWI was voting on a public affairs resolution on the employment of more midwives, moved by Horwich WI in the Lancashire Federation:

'There are chronic shortages of midwives. The NFWI calls on the Government to increase investment in the training, employment and retention of midwives in England and Wales to ensure services are adequately resourced and are able to deliver a high standard of care.'

A little bit of research told me that Professor Lesley Page, President of the Royal College of Midwives, was to debate the issue with Nick Bosanquet, professor of health policy at Imperial College, London.

On arrival at the Royal Albert Hall, I was shown to the press box and saw the venue was full to bursting with WI members of all ages. I was just in time to hear their guest speaker, Lord Julian Fellowes, speaking most amusingly about his admiration for strong women, and how they had influenced his portrayal of characters in such successes as *Gosford Park* and *Downton Abbey*.

The resolution on employment of more midwives was then proposed by Susan Baines, who is both a midwife and a WI member. She explained that midwives are the experts in normal childbirth, but their role is becoming ever more demanding and complex due to the impact of social change, increasing immigration, poverty and social deprivation combined with new technologies and the reduction in junior doctors' hours. At the same time, the birth rate continues to rise and midwife numbers have not kept up, resulting in increased numbers of operative births. Sue also described how midwifery support is important both for safety of women and for their satisfaction with their care which helps them become more effective parents.

Lesley Page then took the stand to give her support and that of the RCM to the resolution. She agreed with the proposer's view that having enough midwives to support women was important both for women's safety and to put them on the right path to parenting. She acknowledged the increase in the number of midwives over recent years: 2,500 more under the previous government and almost 1,000 under the current government, together with increases in places for student midwives. However, she told the WI members that this has to be seen in the context of the rising birth rate. Between 2001 and 2010, the number of babies born in England rose by an astonishing 22%, with that rise predicted to be 28% by 2015. In Wales, the birth rate rose 19% between 2002 and 2010 but the country now has its lowest number of midwives since 2003.

Not only are there more women giving birth, but those women now tend to be older, more ethnically and socially diverse and with more multiple pregnancies due to increases in fertility treatment. Without an increase in the number of midwives the safety of women and the quality of the care they receive will be compromised.

In Lesley's view, there is a real risk that safety of birth for both mothers and babies would be compromised without more midwives available to provide one-to-one care and a minimum ratio of one midwife to every 30 births.

The single most important thing the Government could do, she continued, would be to increase the number of training places for student midwives. Further ways to improve the situation would be for more births to take place in out-of-hospital settings, such as at home and in midwife-led units, and for appropriately trained and supervised maternity support workers to perform some tasks traditionally undertaken by midwives.

investing in the start of life would pay rich dividends

She concluded by saying that scrimping on midwifery services in the short term would short-change the next generation, but investing in the start of life would pay rich dividends.

Professor Nick Bosanquet then spoke opposing the resolution. His stance was that investment in training was a long-term answer and that more immediate solutions were needed. He set out six steps that would help midwives in the short term and reduce variability in the quality of care:

1. More support for units that face problems, including setting up networks between them and units achieving good results.
2. Improving the information base so we can more readily identify the units that need most help.
3. Increasing support and training for qualified midwives to feel more confident in their skills.
4. Ensuring that women have a named midwife to increase continuity of care.

5. Increasing links with the voluntary sector such as Netmums, Mumsnet and 4Children.
6. The Women's Institute to play an important role in adopting local units, showing support and fundraising for equipment.

the same fate as Tony Blair in 2000 – the WI slow handclap

Professor Bosanquet's last step did not go down well with the WI audience who, I assume, found his attitude towards them somewhat patronising. He began to suffer the same fate as Tony Blair in 2000 – the WI slow handclap. He wrapped up his speech quickly and sat down.

Points were then taken from the floor, both supporting and opposing the resolution. Some questioned where the money to fund this resolution would come from, with concern that it would be taken from other NHS services which also badly needed funding. There was support for home births and midwife-led units, but a concern that these services were being cut rather than supported. There were questions about how midwives could be retained within the service, and how experienced midwives who were retiring were going to be replaced. WI members who were also midwives spoke about how difficult it could be for qualified midwives to find jobs, and how the job was so difficult because it was so busy and there was a lack of support.

The resolution was then voted on, and the result announced later in the day. 96% of members had voted in favour of the resolution which will now become the campaigning focus for the next year.

Although my business was over for the day, I was invited to stay on for the rest of the AGM and I am so glad I did. It involved an attempt at the world record for the largest number of knitters in one place; a presentation from the remarkable space scientist Dr Maggie Aderin-Pocock, born in Britain to Nigerian parents and brought up on a council estate, who spoke to the WI carrying her two-year-old daughter in a sling; dancers from Strictly – Robin, Kristina, Artem and Kara – previewing their new show; and finally the very moving 'Jerusalem' and Welsh national anthem sung by the entire hall. I left clutching some WI biscuits and jam, full of admiration for this group of amazing women.

Miranda Dodwell

Lesley Page's speech is available at www.thewi.org.uk/__documents/public-affairs/2012-agm/professor-lesley-page,-rcm.pdf

Nick Bosanquet's speech is available at www.volterra.co.uk/uk-midwife-shortage/

Thank you

AIMS would like to say a very large thank you to Sacha Lane. Sacha raised money for AIMS by being sponsored to run the Cardiff half marathon, no mean feat!

Thanks to Sacha's amazing effort, she raised £405!

This money will help us to help more women like Sacha, who came to AIMS to unravel two traumatic birth experiences. We were able to provide her with information and confidential support to help her make sense of what had happened to her.

We are always amazed by the lengths our members go to to support us!

‘No alcohol, no risk’

Gill Boden reports on the FASD information for midwives

This 26-minute film has just been released by NOFAS-UK, the National Organisation for Foetal Alcohol Syndrome UK. It examines the risks of drinking alcohol in pregnancy and follows a birth mother with a child with suspected fetal alcohol spectrum disorder (FASD), a midwife and a pregnant woman who is drinking low levels of alcohol. The focus of the film is the message that the only safe advice is to abstain from alcohol at all stages in pregnancy.

The three women and, through them, the viewers are shown some quite shocking footage of children with deformed features and very challenging behaviours, all of whom have been removed from their presumably alcoholic mothers and fostered. There is no information on the levels of alcohol during pregnancy that would result in such damage, but it is very clearly stated that the standard advice, that ‘one or two units once or twice a week’ should cause no harm, is based on no evidence at all. The only evidence offered of the effect of alcohol in pregnancy is ultrasound scanning showing the foetus reacting to, presumably low, levels of alcohol in the blood of the mother, but it was explained that these visible reactions can’t be interpreted.

There is an irony here in that the logical conclusion that *‘FASD is a direct result of prenatal alcohol exposure and can be completely eliminated if pregnant women do not drink alcohol’* could equally well be applied to diagnostic ultrasound. The toxic effects of ultrasound exposure, for example low birth weight, which are direct effects of high levels of ultrasound, could be completely eliminated if pregnant women did not submit themselves to routine screening.

All three women were convinced that women need more information about the effects of alcohol and that a policy of advising no drinking is best. While this may be the case, what is not explored in the film is the repercussions of such a policy in a society where social drinking by women is prevalent and many women do not plan their pregnancies, or do not know immediately when they conceive. It is also the case that European societies have relied on fermentation to keep liquids free from bacteria for thousands of years and women and children have regularly consumed weak beer for probably centuries.

what is not made explicit is the kind of sanctions that society might impose on women who for whatever reason, don’t take, or can’t take the advice

I feel that what is missing is a consideration firstly of how drinking habits and strength of drinks have changed, and secondly what support women who are heavy drinkers need and get. Finally, while the language of the film is about education, what is not made explicit is the kind of sanctions that society might impose on women who for whatever reason, don’t or can’t take the advice. It was stated that 30 children are taken into care in the UK every day and the largest single group within this is children suffering from FASD. We know that in the US women are being imprisoned for drinking ‘too much’ while pregnant. I believe we need far more research into the effects of low and moderate levels of alcohol in pregnancy so that we know what will damage babies. We need to challenge the punitive treatment of pregnant women: women whose behaviour may damage themselves and their babies need help and support, not punishment.

Gill Boden

To view the film online, go to www.nofas-uk.org, section ‘Alcohol in pregnancy – training for midwives’. There is also a fact sheet for parents, carers and professionals containing information on fetal alcohol spectrum disorder.

Freedom for birth

Lisa Sykes organised the global premiere, Halifax screening, on 20 September 2012

At our local home birth support group, over tea and cake, as most serious business is conducted, independent midwife Susan Stephenson and I decided we would try to pull together a local screening of the human rights in childbirth documentary, Freedom For Birth.

Susan had already taken delivery of the film and some marketing materials, so we just needed to secure a venue and get the word out so that we had someone to show the film to. Susan had the inspired idea to contact a local high school with a media and arts specialism to see if they would host the screening. They were happy to oblige and so we set to work promoting the screening over the next two weeks. We were keen to ensure this wasn't just a 'preaching to the converted' exercise and set about pulling together a panel for questions and answers after the film. We distributed flyers and spread the word across social media. We were really pleased to have a reply from our local MP's office, confirming he would be attending, and also from one of the most senior midwives in the area. We invited another midwife from a neighbouring trust to join our Q&A panel and she was keen to come. Disappointingly her head of midwifery would not allow her to be at the screening, claiming it was felt to be 'too radical', despite the film being backed by the Royal College of Midwives and featuring Cathy Warwick and Lesley Page.

In my mind, given the short timescales we had arranged things in, if a dozen people turned up I'd class that as a success. In the event we saw around three times that number join us in the school lecture theatre. We had a good mix – practising midwives (both NHS and independent) students and teachers from the school, mothers with babes in arms, doulas, student midwives and aspiring student midwives, and politics students. Our local paper covered the event and, interestingly, the MP did not want to be photographed prior to the screening – who said birth isn't political?

who said birth isn't political?

The day of the screening was the first time I had seen the film. Susan had watched it in advance to prepare some points to get the discussion flowing afterwards. I was very quickly moved to tears listening to the passion of the many birth experts and advocates. The film goes on to tell the now familiar story of Hungarian obstetrician turned midwife, Ágnes Geréb, and other stories of abuses of human rights in childbirth across the world. One woman in The Netherlands tells her story of being arrested for considering a home birth with a midwife when pregnant with twins and her subsequent forced caesarean section. Another woman in Florida was subjected to the same – arrested and her baby surgically removed – for not signing a hospital blanket consent form. Even for someone who knows of the abuses of women in childbirth it made upsetting and disturbing viewing. Many of the audience sat open-mouthed in disbelief at what they were hearing. The ray of light was the ruling passed down by the European Court of Human Rights. In the case of Ternovszky v Hungary, brought by one of the thousands of mothers who had been cared for by Ágnes Geréb before her imprisonment, Anna Ternovszky put it that she had been denied the opportunity to have her baby at home as midwives were effectively dissuaded from assisting her because they risked prosecution like Ágnes. The court found that she was in effect not free to choose to give birth at home and, as such, her human right 'to respect for private and family life' had been violated. I don't think we can underestimate the importance of this ruling.

At the end of the screening the lights went up and there were several people, myself included, wiping away tears. We opened the floor to discussion, with the consultant midwife, the MP and me at the front of the room. My perception of his body language was that the MP couldn't have been less interested. Susan prompted our audience by asking how the film had left people feeling. One woman, who identified herself only as a midwife, said the film left her feeling incredibly frustrated, unhappy that a lack of staffing and support meant that she found it almost impossible to give women the kind of care she felt they deserved. She said she was ready to quit midwifery. The consultant midwife was quick to try to talk about the good work that was being done in maternity services locally and how choice was supported in our trust. The discussion could have gone on for much longer but we were very restricted for time. One mother remarked that choice may be supported on the surface, but that message was not the one coming from some midwives on the ground. Locally women are still being told they are 'not allowed' home births for various reasons and informed choice is not being truly supported. When a woman talked of her choice to birth unassisted to avoid being 'abused by the system', she was labelled 'irresponsible' by the MP. For many others in the room the question was, 'How is a woman made to feel that declining clinical care is the only way to be treated with respect and dignity in birth?'

The MP also said that he received many letters on many matters but 'birth' and 'maternity services' were not topics that had ever landed on his desk. Perhaps it's time they did. Most people in the room were also unaware of the issues facing independent midwifery.

Our main objective was to get the film's message to someone new and I think we did that. Students said they were shocked. One was inspired to research other human rights abuses in childbirth and spoke about wanting to 'do something about it'. The aspiring midwives were the ones who seemed most shocked by what they saw and heard. One young woman said she had no idea about 'any of this' and that she thought things were 'just like they are on One Born Every Minute'. Doesn't that say so much?

Our long term aim for the film is to get it seen by as many young people as possible. If we are going to effect change then we need to change the culture and perception of the next generation before they come to maternity services as parents-to-be. The film is going to be showing in other secondary schools to students as part of their citizenship studies and to politics students too.

The day after the film I literally couldn't stop thinking about everything raised.

This is not a 'natural childbirth' issue. It's not even just a home birth issue. It's about fundamental human rights. It's about abuse, power and control. It's about the continued erosion of real choice. It affects all birthing families regardless of their choices: home, hospital, vaginal, surgical, assisted, unassisted. ALL of us. Your children and mine.

Lisa Sykes

Information from One World Birth

Women claim their rights in childbirth with a powerful new documentary premiered simultaneously in 1,000 locations in over 50 countries in 17 different languages.

Suggestions for action:

- Connect up with people like yourselves who are taking action.
- Use our facebook.com/oneworldbirth community to reach out to other people.
- Tell us what you are doing: email us at info@altofilms.com and we will update our freedomforbirth.com website
- Organise more screenings
- Blog about it, share/tweet/post about it, tell your friends and family, get it reviewed in your local media.

Most importantly enjoy it!

Soon after the screenings, we're going to be releasing a short version of the film on the internet for free so we need everyone to share it widely to make it go viral – so it's seen by millions!!!

We will be creating and releasing more videos to educate people about birth – so keep an eye on oneworldbirth.net and tell people about FREEDOM FOR BIRTH – freedomforbirth.com

Birth centre against the odds

Caroline Willett shares her birth story

In 2007, towards the end of my first pregnancy, I developed high blood pressure so was closely monitored. I went to the NHS antenatal classes and thought we were prepared. When I came to give birth I was totally unprepared, confused and terrified.

After a stressful and difficult labour my son was delivered by ventouse and everyone was glad it was all over, but I was left feeling totally wiped out. After I'd been stitched up, it very quickly became clear that something was wrong, so I was whisked into theatre to fix a haematoma and I was so upset that everything seemed to be going wrong. As I'd had an epidural in theatre, I spent the night looking over at my baby through the side of the cot because I couldn't get up to see him or hold him, and I spent a very upsetting and stressful week in hospital afterwards. By the time we took our son home we were physically and emotionally exhausted. I suffered terribly with postnatal depression, which wasn't noticed by my health visitor until very late on. I didn't think I'd ever have another baby.

ready to face having another baby

When my son was around three I started feeling as though I'd love him to have a little brother or sister and was starting to feel ready to face having another baby. When I became pregnant I started to panic and realised I wasn't sure if I could do it again, but I did want the baby so I had to get through it somehow. I kept panicking, having nightmares about my son's birth. Every time I went for a hospital appointment I panicked and felt ill in the waiting room. The hospital told me that because I'd had high blood pressure and a difficult birth the first time it would probably happen again this time and I'd have to be monitored very closely, so I had many many hospital appointments and felt very scared of the whole thing.

Whilst at my scan appointment I saw a poster for HypnoBirthing, advertising a way to a calmer more positive birth and we contacted the lady straightaway. We hired a lovely doula and, through the support and education of our HypnoBirthing classes and our doula, we were determined to be more knowledgeable about pregnancy and birth and having a new baby. We began to prepare ourselves for the calm and happy journey that was ahead, instead of the terrifying and awful journey that I'd first thought I was going to have. I became confident enough to speak to the doctors and midwives and discovered that what had happened first time around wasn't necessarily going to happen again this time.

The hospital told me that because of my previous difficulties I wouldn't be able to use the birth centre or a birthing pool or be active in labour as I'd have to be closely monitored, but I didn't agree.

I was nearing the end of my second pregnancy when my husband decided we should go and look around another hospital. We told them our history and they were lovely and supportive and welcoming to the kind of birth I wanted and were happy for me to use the birth centre (midwifery-led care unit) and showed me around. It was so lovely and peaceful with fairy lights, a birthing pool and no doctors, I was so excited.

Through the help of my doula and the HypnoBirthing skills I was learning, all my fear and panic was melting away and instead of being scared I was excited and couldn't wait to have my baby. When I went into labour I felt calm, happy and excited. We went to the birth centre and got settled in. My blood pressure was slightly high and I was bleeding heavily, but baby and I were doing great and nobody was at all worried that I couldn''t continue in the birth centre.

Everything moved quite quickly and I had the most amazing water birth experience I could have wished for. There were a few moments when the panic started to set in, but everything went smoothly and my daughter was born in the birthing pool. She wasn't crying or anything, she was just so peaceful and I was so so happy that I'd actually done it. I'd gone from feeling like I couldn't have another baby to just having the best birth ever. My daughter is such a peaceful happy little girl and I put that down to the lovely pregnancy and birth she had.

For the first time in years I was truly happy.

Of course it wasn't without its mishaps, I was on crutches for the last few weeks of pregnancy due to having bad pelvic pain, but despite the ups and downs we got over them all and everything was amazing. For the first time in years I was truly happy. My son is amazing with his baby sister and we're all doing great.

There was no depression after my second baby and I put that down to having such a positive experience.

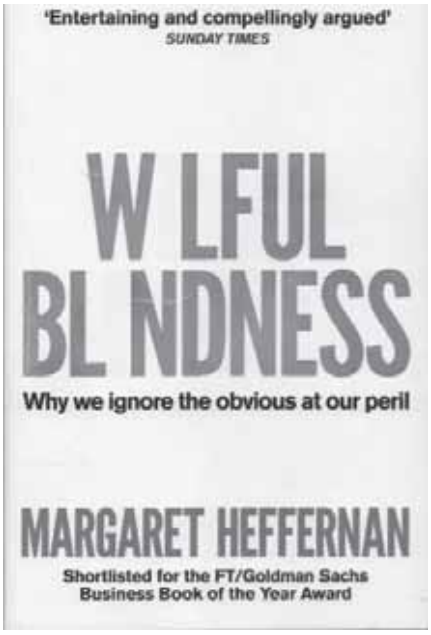
I can't thank my doula and my HypnoBirthing teacher enough and my husband was an amazing support throughout everything. I'm a very lucky lady.

Caroline Willett

Reviews

Wilful Blindness: Why we ignore the obvious at our peril

By Margaret Heffernan
Simon and Schuster, 2012
£8.99
ISBN-13: 978-1847399052



Wilful Blindness is not about birth, but was recommended to me by a thoughtful and committed midwife, who has suffered from the wilful blindness of those around her. It is the result of excellent investigative journalism and hence easy to read and engaging.

As it happens, it includes a section on Alice Stewart (of *The Woman Who Knew Too Much* by Gayle Greene, well worth a read and reviewed by Jean Robinson in AIMS Journal Vol 15 No 3). Alice discovered, through careful research, that x-rays harm unborn babies, but because of the beliefs of her day, her discovery was vigorously rejected, and it took many years – 25 to be exact – before it was accepted. Meanwhile many more babies suffered because of wilful blindness. This book is about how we are all blinded by our beliefs and values, both individually and collectively, and how we are drawn to those who share those beliefs and values.

even when new knowledge is blindingly obvious, it can be ignored and, worse still, strenuously rejected over a long period of time

The book explains how even when new knowledge is blindingly obvious, it can be ignored and, worse still, strenuously rejected over a long period of time. The bearers of new knowledge might well be cast as trouble makers – mad, bad or sad. The book is helpful because it includes us all. It shows how systemic problems make it difficult for us to be open and curious. It provides a different kind of understanding about why change is very difficult to bring about. And yet the author does not shy away from individual responsibility and accountability: it is both shared and individual and the author brings both to account. The stories exposed in the book are both fascinating and horrifying. Well worth reading.

Nadine Edwards

Supporting women to give birth at home: a practical guide for midwives

Edited by Mary Steen
Routledge, 2012
ISBN: 978-0415560306
£23.99

A cover of a book can be very influential. It can give a good impression of the contents or it can completely put one off buying it. This cover's photograph shows a woman lying on her back with her baby on her stomach and two small children looking decidedly wary in the background. Not a good beginning and, I regret to say, any enthusiasm I might have had for a book that supposedly was written to support women to birth at home was gradually eroded as I read on.

Language, as Mary Cronk has frequently pointed out, is important; and so are the rights of the woman. It is unfortunate, therefore, that far too often the text refers to the woman being 'allowed', when it is the woman who does the allowing and the midwife who is required to advise her. *'The mother should be allowed to moan, sob, grunt or scream as the second stage of labour progresses.'* (p143).

Even when advice is referred to, there are overtones of compulsion and a mis-understanding of the rights of the midwife; for example: *'Whereas the woman herself should be in control of who is present for the birth and supporting her, the midwife must be present for monitoring the progress of labour and for delivery.'* (p26). Midwives have no right to be present and women are not obliged to contact

midwives when they intend to birth at home; this erroneously suggests that they must.

This misinformation is compounded further: *'should there be a divergence of views on treatment, the midwife's professional opinion should be considered and the clinical route forward must be the one that she is advocating.'* (p130). The midwife is there to give the woman the benefit of her advice – whether or not the woman takes it is entirely up to her.

This book adds to that confusion

Midwives' lack of knowledge of the law is understandable when far too often they are misinformed. This book adds to that confusion: *'It is illegal for a partner, family member or friend to intentionally plan to replace a skilled professional at the birth.'* What the law actually states is that *'no person other than a registered midwife or a registered medical practitioner shall attend a woman in childbirth.'* By 'attend', the law means perform clinical tasks and give medical care; it does not cover the simple act of being there to offer practical and emotional support. It does not give the medical professional the right to be there; it prevents those without registration pretending to hold a position when they do not. The law makes no mention of *'replacing a skilled professional'* and there is nothing illegal about a woman choosing to birth with her husband, partner or friend who will be there to support her. It is up to her whether or not she calls a midwife.

I would have expected a book that really supported women to give birth at home to have had a detailed discussion of the dilemmas that a midwife could face, not least what to do when a woman persists in stating that she is staying at home. Instead, the advice is *'Women deemed to be at higher risk should be actively encouraged to give birth in a consultant-led maternity unit.'* The line between 'active encouragement' and coercion can be very fine indeed, and it would have been helpful to have a discussion of the principles of informed consent and informed refusal. Instead, the phrase *'it is essential to ensure that women understand the implications of any actions they decide to take'* is repeated in various forms throughout the book.

'An appointment will be made with the woman to discuss her plan of care … however, women must not be "protected" from understanding the possible implications of their decisions'. (p131). In other words, feel free to repeatedly bully her. Which makes the following sentence most intriguing: *'The training should include conflict resolution and educating midwives about the practicalities of using break away techniques.'* (p129). Just who is this conflict resolution aimed at? Is it dealing with a stroppy mother or a difficult colleague?

When talking about the role of the doula, it states: *'They cannot challenge medical or midwifery advice given to the woman or persuade her against a course of action or treatment suggested by the medical team.'* (p130). Why not? A doula is employed by the woman to give her support in labour and has a responsibility to comment on any advice that is contrary to the woman's wishes or to act when poor practice is witnessed. Standing silently by while knowing that poor practice is being advised or undertaken is unethical.

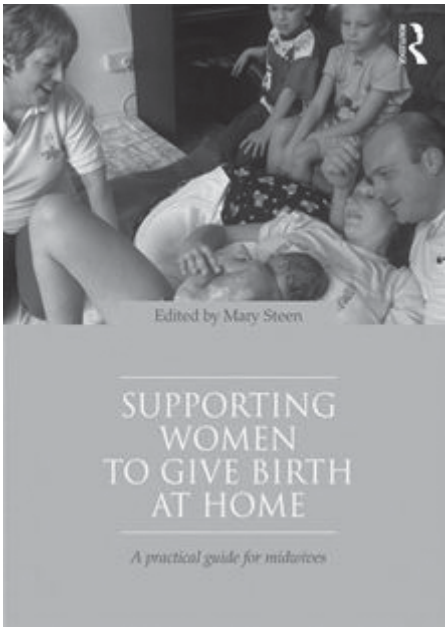
Space prevents me from commenting on the inaccurate clinical advice that is evident throughout the book except to draw attention to the comment on page 175. Having stressed the maxim 'hands off the breech', the advice then lists the action to be taken as the baby emerges. So much for 'hands off'! And in the section dealing with a baby unexpectedly born showing little sign of response or activity, the advice makes no mention of the importance of keeping the cord intact. (p188).

The book gives an impression of being written from a management perspective and not by midwives with an intimate knowledge of home birth.

I do not see that this book will help a midwife attending a home birth

I do not see that this book will help a midwife attending a home birth, and it is certainly not a practical guide; indeed I suspect that following its advice could well lead to any number of difficulties.

Beverley A Lawrence Beech



JOURNALS & BOOKS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MISCELLANEOUS

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

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Noticeboard

AIMS Meetings

Friday 11 January 2013, Bristol
Friday 15 March 2013, London

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

AIMS Extraordinary General Meeting

Friday 11 January 2013, Bristol
See the enclosed flyer for further details

AIMS Event

Inspiring midwives and women presentation by Gina Augarde
Thursday 10 January 2013, Bristol
Contact Chloe Bayfield
email chloe.bayfield@aims.org.uk

University of Birmingham
International Conference on Transitional Care
Cutting the Cord
19 April 2013
Birmingham

As well as cord clamping, other topics for discussion include:
How safe is home birth?
Can positions speed up childbirth or help to reduce obstetric trauma?
What are the pros and cons of different forms of pain management?

To register your interest please email the CPD office med-cpdbookings @contacts.bham.ac.uk

MaMa Conference

biology, psychology, politics and practice of maternity care

26 & 27 April 2013
Assembly Rooms, Edinburgh

Confirmed Speakers:
Sheila Kitzinger, Soo Downe, Sheena Byrom, Joy Horner, Michel Odent, Amali Lokugamage, Mary Steen, Kathryn Gutteridge, Kerstin Uvnäs-Moberg, Margaret McCartney, Clare Willocks, and Ina May Gaskin.

For more information please visit the website:
www.mamaconference.co.uk

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

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