

AIMS JOURNAL

VOL 24 NO 1 2012

ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES



"Please treat me normally"
Women share their thoughts
on care

VISIT AIMS ON THE WEB: WWW.AIMS.ORG.UK

contents

Cover Picture: © Hannah Robertson. Hannah avoided induction and had a peaceful home birth with baby Daisy.

Editorial		My birth story	17
The emperor has no clothes	3	<i>Catherine Rennie</i>	
<i>Beverley Beech</i>			
Articles		I would have just gone quietly ...	21
Saving mothers' lives	4	<i>Holly Lyne</i>	
<i>Nadine Edwards</i>		Birthing identical twins	23
The problem with complaining	8	<i>Robyn Hall</i>	
<i>Louisa</i>		Reviews	
Dear BBC	10	Midwives Coping with Loss and Grief	24
<i>Holly Lyne</i>		<i>Rosemary Mander</i>	
Report		Birth Pain: Power to Transform	24
Maternal mortality in the UK	11	<i>Ruth Weston</i>	
<i>Shane Ridley</i>		Letters	26
Readers' forum		Publications	27
Reflections on birthing	12	Noticeboard	28
<i>Susannah Sweetman</i>		AIMS membership form	28

Helpline
0300 365 0663
 helpline@aims.org.uk

Hon Chair
Beverley Lawrence Beech
 5 Ann's Court, Grove Road, Surbiton, Surrey, KT6 4BE
 Tel: 0208 390 9534 (10am to 6pm)
 email: chair@aims.org.uk

Hon Vice Chair
Nadine Edwards
 40 Leamington Terrace, Edinburgh, EH10 4JL
 Tel: 0131 229 6259
 email: nadine.edwards@aims.org.uk

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

Hon Treasurer
Vacant

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

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

Hon Secretary
Gina Lowdon
 Tel: 01256 704871 after 6pm and weekends
 email: gina.lowdon@aims.org.uk

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

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

Volunteer Coordinator
Ros Light
 Tel: 01423 711561
 email: volunteers@aims.org.uk

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

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

Hon President: Jean Robinson

Founded by Sally Willington 1931 – 2008

Invitations have recently gone out to AIMS members inviting them to join the AIMS Members Yahoo Group. If you are not already on the group and have not received an invitation, this probably means that we do not have an up-to-date email address for you. If you would like to update your email address on our database, please email membership@aims.org.uk including your postcode.

Being a member of the group will not only allow you to have contact with other AIMS members and to hear what the current issues are for them, but also will allow the committee to keep you up to date with what we are doing, when and where the next meetings are planned to take place and what you may be able to do to support AIMS.

health.groups.yahoo.com/group/aimsukmembers

VOL:24 NO:1

ISSN 0265 5004

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

Printed by
QP Printing, London
 email: info@qpprinting.co.uk
 Tel: 07593 025 013

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

©AIMS 2012
 Association for Improvements in the Maternity Services. All rights reserved.
 Please credit AIMS Journal on all material reproduced from this issue.

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

Data Protection Act
 In accordance with the DPA, any member is entitled to ask: 1) for a printout of his/her personal details as kept on the AIMS computer; and 2) that his/her personal details should not be stored.

The emperor has no clothes

Beverley Beech looks at what went wrong with improving maternity care

In 1993 the House of Commons Select Committee published its report of its investigation into maternity care. Finally, we saw that an influential body had understood what women had been saying for years. We expected change; recommendations to be implemented; the quality of maternity care to improve enormously; and we expected women to be cared for by skilled midwives offering care in the women's own homes or in small birth centres, and for obstetric units to care for those women with complications who really needed their care.

So, what went wrong?

The policy of building bigger and bigger units, without any research demonstrating that these units improve care, continued unabated. Midwives moved into universities, where they became skilled at studying and undertaking research, but in the process lost the vision of being 'with woman'; they also lost the skills of attending women expecting babies presenting by the breech, or twins.

Some midwives saw the opportunity to establish real birth centres, which were women focused, free-standing and designed to develop midwives' skills; and some supported a growing home birth service for those who did not want to leave their homes for the birth. Slowly, the midwives gained confidence, their transfer rates dropped significantly, women were delighted with the care they received, and their outcomes were far better than those of the centralised obstetric units.

The Albany Midwifery Practice carefully researched its outcomes and was revealed as the Gold Standard for quality midwifery and as a result became a target for closure. Over the years, innumerable numbers of these small midwifery practices and free-standing midwifery units have been closed down, often on the spurious grounds that they were not used enough or that the obstetric unit was short of staff and the midwives were needed there; and, in the case of the Albany, a spurious allegation that they were not 'safe'.

In Wales, a strategy for normal birth was developed with a target of 10% home births. Years later, it has yet to be achieved, but at least they are trying; no other region in the UK gets even close to that figure.

Despite a growing mountain of research demonstrating that one-to-one, case-load, midwifery offers the best-quality care, few areas provide this. Instead, Trusts continue with their policy of centralised obstetric care. More small midwifery units are being closed and protests from local people have little effect. The fact that these large, centralised, maternity units (which even the President of the RCOG acknowledged as 'baby factories') are understaffed, and inappropriate places for fit and healthy women, is ignored.

But what is the effect on fit and healthy pregnant

women? They end up having 'ordinary bad births'. They enter hospital fully expecting to have a 'normal' birth, unaware that fewer than 10% will be successful. Instead of having a confident, supportive midwife with them, they will be left alone for a great deal of the time and when their labour slows or stops they will be pressed to agree to an induction or an acceleration. Instead of being supported to follow their body's signals they will invariably be confined to a bed and soon faced with a forceps delivery or a caesarean section. Battered and bruised, they leave hospital convinced that their body was not up to it, rather than understanding that the conditions in these units present huge barriers to successful birthing. TV programmes like 'One Born Every Minute' and 'The Origin of Us' undermine women's confidence in birth and persist in portraying birth as dangerous, painful, and stressful.

Centralised obstetric care prevents midwives from supporting well-motivated women to have normal births. This is not because there are a few 'bad' midwives out there but because of the systemic, structural and ideological problems these huge obstetric units create.

This Journal focuses on the effects centralised obstetric care has on women and midwives. Nadine Edwards summarises the findings of the Confidential Enquiry into Maternal Deaths which highlights that far too many of these deaths were preventable, with symptoms that doctors and midwives should have detected and acted upon; but under our present fragmented, centralised care this becomes almost impossible.

Centralised obstetric care results in a lack of trust in women, the birthing process and midwifery, where policies, procedures and environments, have been set up to measure, check and generally interfere. There is a belief that birth is likely to end badly rather than go well. Few women complain. As Louisa explains on page 8, the trauma of an 'ordinary bad birth' is just too hard to address for many years – a not uncommon experience.

Susannah Sweetman and Catherine Rennie describe their first 'ordinary bad birth' and Susannah goes on to describe a beautiful second birth at home, but one that she had to fight for. Fit and healthy women should not have to go through an 'ordinary bad birth' before they can explore the possibilities and arrange a good, straightforward, empowering birth for the next baby.

Since the publication of the Winterton Report, we have known what is needed to give women and babies the best chance of a good birth, and the pile of supportive research grows by the day; but we have failed to find an effective means of implementing real change in the face of a medicalised structure that is determined not to change.

Beverley A Lawrence Beech

Saving mothers' lives

Nadine Edwards summarises the Eighth Report analysing Maternal Deaths

This Report¹ makes traumatic reading, covering as it does the deaths of women in the UK from 2006-2008 who died during pregnancy or birth or during the days, weeks or months after birth. '261 women died in the UK directly or indirectly related to pregnancy' (p1). Overall this is 11.39 women per 100,000 maternities.

Although maternal deaths are rare, analysis of their causes and failures is crucial, and also helps the larger numbers of women who suffer 'near misses' and may be seriously ill.

The overall findings of the Report are that fewer women died of direct causes, such as thromboembolism and haemorrhage. There was also a lower rate of death attributed to deprivation and lower socio-economic status – though this is very much still an issue. More women died who had Group A streptococcal infections. The Report 'identified substandard care in 70% of Direct deaths and 55% of Indirect deaths' (p1).

'The overall aim is to save the lives of as many mothers and newborns as possible through the expert anonymous review of the circumstances surrounding and contributing to each maternal death in the UK [...] to learn wider lessons and to formulate and disseminate more general recommendations' (p25). To do this, the Report is divided into 17 chapters, and appendices. Each chapter, by different authors, looks in depth at various causes of maternal deaths along with the care the women received. It provides specific recommendations for health care workers and outlines lessons to be learnt in that particular area.

The authors of the Report have also identified the 10 most recurrent problems arising from the chapters, along with urgent recommendations. The full Report with these recommendations is available free of charge on onlinelibrary.wiley.com/doi/10.1111/bjo.2011.118.issue-s1/issuetoc, but can be summarised as follows:

- Pre-pregnancy counselling should be available for all women with medical conditions and ideally for all women.
- Professional interpretation services should be available for all women who do not speak English.
- When referrals are made to specialist services, these should be dealt with urgently, and good communication, and follow up, is essential.
- Women with serious pre-existing medical or mental health conditions, or who develop them during pregnancy or after birth, should be referred immediately to specialist centres of expertise.
- Clinical staff should have regular training in responding to obstetric emergencies and emerging emergencies, such as sepsis, and medical and mental

health conditions.

- Health practitioners need to be able to identify and manage very sick women, and MEOWS (modified early obstetric warning score) should be used routinely in all women who become ill in pregnancy or after birth.
- Women who develop pre-eclampsia or have other signs, such as raised systolic blood pressure, should be treated urgently.
- All pregnant women and those who have recently given birth should get information about the risks, signs and symptoms of sepsis and how to prevent it by washing hands before and after going to the toilet or changing sanitary towels and being especially careful if they or their close contacts have a sore throat or upper respiratory tract infection. Health practitioners, particularly community midwives, need to be able to recognise signs and symptoms of developing sepsis and refer women immediately. Sepsis is complex and not well understood and while some deaths will be unavoidable, early aggressive intravenous antibiotic treatment is crucial.
- There needs to be a high-quality review of any maternal death. Many were of poor quality with little evidence of reflection and critical analysis, to the extent that, in some cases, the authors found 'no evidence that obvious lessons had been identified, let alone learnt' (p14).
- Better maternal autopsies are needed.
- We need national guidelines on the identification and management of sepsis and on how to do, and act on the results of, serious incident reviews.

the need to improve basic medical and midwifery practice

Key research questions identified by the report included looking at the impact of reduced postnatal visits, examining the social, service and clinical factors that mean that mothers from certain minority ethnic groups are still more likely to die, identifying barriers to rapid communication, referrals and appointments for ill women, and determining whether or not the increase in sepsis and Sudden Adult Death Syndrome is real.

The authors include a Back to Basics section. Somewhat concerning, this includes improving basic medical and midwifery practice such as history taking, basic observations and understanding normality. It also identifies the problem of health practitioners attributing signs and symptoms of emerging serious illness to common symptoms. Improving communication and

referrals is stressed throughout the Report and is highlighted here too. Many examples are given where failures in these basic requirements may well have contributed to a mother's death.

The main causes of direct maternal deaths are sepsis, pre-eclampsia/eclampsia, thromboembolism, amniotic fluid embolism, early pregnancy deaths, haemorrhage and deaths due to anaesthesia. The main cause of indirect deaths is cardiac disease. 26% of the women who died received little or no antenatal care, 42% who died had shared care between GPs, midwives and obstetricians and 37% of the women had not yet given birth. One of the most experienced authors, Gwyneth Lewis, suggests something that AIMS has been concerned about for some time – that mothers who are threatened that their baby will be taken into care may have committed suicide, and that the fear of a baby being taken at birth might make vulnerable mothers, in need of support and care, avoid maternity services.

Many of the chapters in the Report highlight obesity and educating the community about sepsis as major problems – though in AIMS Journal Vol.23 No.4 Rosemary Mander, Ruth Deery and Sara Wickham suggest that the issues involved are complex and suggest some caution, as these can become a way of blaming women for their own deaths and morbidity and obscure other failures of health care.

Fragmentation of care, lack of continuity, and poor follow-up, along with high levels of busyness in hospitals, feature in many of the chapters.

In the chapter on thrombosis and thromboembolism, the author suggests that chest pains are not being investigated and that any chest symptoms occurring for the first time in pregnancy or after birth should be taken seriously. The chapter on pre-eclampsia and eclampsia also mentions numbers of symptoms that are not always followed up and suggests that: *'The single major failing [in clinical care] in the current triennium was, again, inadequate treatment of hypertension'* (p68), and that the use of syntometrine for the third stage of labour should be avoided if a woman has hypertension or if her blood pressure is unknown. As the chapter on haemorrhage makes clear, severe bleeding can occur during childbearing for various reasons, but one of the reasons highlighted is placental problems following previous caesarean sections.

The author of the chapter on amniotic fluid embolism (AFE) suggests that with excellent care: *'Amniotic fluid embolism should no longer be regarded as a condition with near universal maternal mortality'* (p77). It is significantly associated with induction of labour, but there is apparently no association between induction and fatality. If a mother does die from AFE, however, it is important that an autopsy is carried out very quickly, as otherwise a diagnosis of AFE is difficult or impossible. In the chapter on deaths in early pregnancy, one key message is to consider pregnancy when women present at Accident and Emergency, especially with diarrhoea, dizziness and vomiting. The author worryingly points out that this is one of the lessons that has not been learnt from the previous Report on maternal deaths. Although very

different issues, the chapters on maternal deaths from sepsis and anaesthesia both identify similar failings for similar reasons – that both need swift and correct treatment from the right senior practitioners. Communication is key. Not surprisingly, but of no less concern, both chapters identify from the case reports that *'providing good high-dependency care was difficult when the maternity service was already busy'* (p 102). The chapter on deaths involving anaesthesia concludes:

'A number of case reports highlight that peak labour ward activity coincided with the emergency admission of a pregnant woman with an acute, severe illness. Many notes suggest that the midwifery, obstetric and anaesthetic workforce was already fully committed at times of peak activity in normal workload. This produces difficulties if a pregnant woman with an acute, severe illness is admitted and requires high-dependency care in addition. When staffing levels are calculated on average activity, there needs to be a clear contingency plan for all disciplines to obtain further skilled assistance' (p108).

In the chapter on cardiac disease, which is the leading cause of maternal deaths overall, once again, one of the main failures identified by the author was practitioners not recognising or investigating signs and symptoms of heart disease, such as pains in the neck, jaw and left arm, nausea and dizziness, and other less common symptoms. In the chapter on indirect maternal deaths, similar patterns emerged – symptoms being missed and not investigated. The authors point out that women who are victims of domestic violence, use drugs, smoke, do not speak English and/or are asylum seekers may be particularly unlikely to receive the care they need. They conclude that: *'This triennium the assessors have been struck by the lack of referral of potentially high-risk women'* (p130).

key messages are: listen to women, give them care which meets their physical, mental and social needs, and provide information that the woman understands

The chapter on deaths from psychiatric causes stresses the need for high-quality specialist services for pregnant women and new mothers and points out that general psychiatric services are often inappropriate. It also stresses the need for specialised mother and baby units throughout the UK. The women who died were aged from 16-40, 90 per cent were white and most had partners and stable lifestyles: *'care needs to be taken not to equate risk of suicide with socio-economic deprivation'* (p135). While the authors suggest that unexplained

physical symptoms of distress and agitation should not be assumed to have a psychiatric cause, they also stress that lack of diagnosis and treatment for women at risk of developing severe psychiatric disorders was prevalent, pointing to lack of specialist services and fragmented care. They also criticised, as AIMS has repeatedly done, the fact that some women were reported to Social Services only because they were a *'psychiatric patient rather than because of specific concerns about the welfare of the infant. It was apparent from their notes that fear that the child would be removed was a prominent feature of the women's condition and probably led them to have difficulties in engaging with psychiatric care'* (p137) and that mental illness should not routinely result in referral to Social Services. Three women committed suicide *'shortly after a decision to remove the child into care'* (p138).

In the women who died from causes apparently unrelated to pregnancy, many died in road accidents, were murdered or died of drug overdoses. The author of this chapter suggests that women need information about positioning safety belts, and that women suffering from abuse need more support and information. Women who do not speak English need interpreters who are not family members, and information about domestic abuse needs to be recorded safely – otherwise this could put women at increased risk of further abuse.

The chapter on midwifery echoes many of the recommendations of the other chapters – that midwives need to provide and record excellent basic observations and care, inform women about the signs of sepsis and the importance of good personal hygiene, refer women to the right senior specialist/s at the right time, arrange interpreters where necessary and provide continuity of care for vulnerable women. The key messages are to listen to women and give them care that meets their physical, mental and social needs, and to provide information that the woman understands. One example given is of a woman who died following an induction with *'no evidence that the risks and benefits had been discussed with the mother'* (p153). The chapter advocates what AIMS has long advocated – continuity of care and carer: *'ensuring continuity of care and carer where possible plays a vital role in protecting the wellbeing of mothers and their babies'* (p156). *'If there is a single "take home" message for midwives it is this: listen to the woman and act on what she tells you'* (p157).

Two potentially contradictory messages are of some concern: the authors describe the midwife in terms of being by the *'[woman's] side, as her companion ... also her advocate'* but at the same time suggest that midwives *'need to develop clear boundaries between advocacy and collusion.'* They then describe the midwife as the woman's *'care navigator'* (p149-50) and there is mention of surveillance. They conclude that while the midwife is the woman's advocate, *'a midwife may be the woman's best advocate by challenging her and helping her to see that the course of action she is suggesting, although not the woman's choice, is in her best interest'* (p157). Perhaps the longest AIMS campaign has been to support women who are being coerced or bullied by health practitioners into

following courses of action that they do not want to follow. When midwives are caseloading and know women well, there is often an exchange of views, with woman and midwife being open and honest with each other. Where there is trust they will both listen to and respect each other. However, when care is fragmented in the way it is across the country, strong, challenging advice from a midwife is often experienced as coercing and bullying.

In the chapter on GPs, the author recommends that GPs need to recognise and act on signs of ectopic pregnancy, cardiac disease, severe asthma, venous thromboembolism (VTE), deep vein thrombosis (DVT), pre-eclampsia and sepsis for example, that they need to be aware of guidelines and act on these for numbers of physical and mental health problems during pregnancy and after birth, and that they need to refer women to specialists when appropriate and make sure that appointments have been made and take place and that other health practitioners have the information they need – *'referral is not treatment'* (p165). The GP is seen as central to co-ordinating care and particularly key for women who have mental health challenges at a time when services are fragmented and overstretched. In one case where the woman died: *'All the health professionals involved in this woman's care worked from different sites, they had no meetings or mechanisms for communication and they were all overstretched. This is a reflection of the current fragmentation of care'* (p164).

lack of confidentiality, and not listening to women

The authors recommend that midwives should have access to women's GP notes, *'preferably'* with the woman's consent. While, in the context of this report, it may seem obvious that more practitioners and agencies should have access to information about women, AIMS has witnessed some of the problems when this occurs: for example, sensitive information being shared inappropriately with everyone and anyone over which the woman has no control, other practitioners prejudging women based on one person's subjective opinion, more inappropriate referrals to Social Services, lack of confidentiality, and not listening to women. The balance is complex. Both the chapters on GPs and midwives recommended that these practitioners should be involved in inquiries when a mother dies and that this was not always the case.

The chapter on emergency medicine highlights the importance of identifying and responding to serious illness and emergencies during the childbearing period, and transferring women to the correct senior specialist if needed. This is particularly necessary in Accident and

Emergency Departments when women present with unexplained symptoms. Common symptoms that can be suggestive of serious illness include pyrexia, shortness of breath, headache, diarrhoea, vomiting, epigastric pain, chest pain, proteinuria, hypertension, abdominal pain and tachycardia. The focus in the chapter on critical care is on early protocol-driven care for severe sepsis – *'time is of the essence in initiating treatment'* for developing sepsis (p175) and responding to severe obstetric haemorrhage. Simulation training is suggested as a possible avenue for exploration; the use of MEOWS, involving senior staff, collaboration and communication are stressed – prompt care, delivered in a structured fashion and by well-trained staff.

The chapter on pathology recommends improving the standard of maternal autopsy. Of the 221 (out of 261 deaths) completed for this Confidential Enquiry, some were *'dreadfully inadequate'* (p181). Most are carried out on the instructions of the Coroner (or Procurator Fiscal in Scotland) rather than to provide a full explanation about the death of a mother.

The Report is meticulous and detailed, with many recommendations about how to improve the substandard care identified by the authors. However, similarly to the King's Fund Report,² the solutions remain mostly within a medical philosophy and model of care which emphasises surveillance, more timely referrals to specialist services, and a reliance on technology once problems develop. It is obviously difficult, within our complex population and services, to balance the facts that most women are healthy and well and remain so during childbearing and that a very tiny number become critically ill and require excellent medical care quickly and at the right level of seniority. However, while the importance of caseloading midwifery care is recognised, the potential for prevention, reduction or earlier identification of problems through midwifery support is still not fully understood, nor is it being fully explored, despite the wealth of evidence in its favour.

Whatever one believes about the underlying philosophy, it is difficult to see how the Report's many recommendations could be put in place, systematically, by a service that is on its knees and continuing to suffer from cutbacks in resources and staff. Asking overstretched practitioners to do more visits, to be more vigilant, to follow up more closely and to become more knowledgeable about research and guidelines seems impossible without investing in staff and services. One cannot avoid fearing that more rather than fewer women will die over the next years, simply because the health services are unable to provide the level of care needed.

Nadine Edwards

References

1. CMAE and Lewis, G (2011) Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer 2006-2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. BJOG Volume 118, Supplement 1. Wiley-Blackwell
2. Edwards, N (2008) Safe Births: Everybody's business. AIMS Journal Vol. 20 No. 3, 18-19

Lies, damned lies and the American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (now called the American Congress of Obstetricians and Gynecologists) is considered by some to be the authoritative body on matters maternity in the USA. One expects, therefore, that its statements are based on facts. The reality is somewhat different.

Last year AIMS was sent a press release from ACOG's President, Dr Richard N Waldman, which stated: *'Attempting a vaginal birth after cesarean (VBAC) at home is especially dangerous because if the uterus ruptures during labor, both the mother and baby face an emergency situation with potentially catastrophic consequences, including death. Unless a woman is in a hospital, an accredited freestanding birthing center, or a birthing center within a hospital complex, with physicians ready to intervene quickly if necessary, she puts herself and her baby's health and life at unnecessary risk.'*

Bearing in mind the paucity of American statistics, AIMS wrote to Dr Waldman and asked for the following statistics for 2005–2009 which, one presumes, would support his claims.

How many:

- booked home births occurred?
- unbooked births?
- booked VBACs?
- unbooked VBACs?
- ruptured uteri occurred during a booked VBAC?
- ruptured uteri occurred during an unbooked VBAC?

Of those ruptured uteri, how many:

- resulted in the death of the woman?
- of those deaths occurred at home?
- of those deaths occurred following transfer to hospital?

In the fullness of time, AIMS received nine pages of statistics which revealed the total number of caesareans, VBACs, the birth rates (but nothing about place of birth, other than freestanding birthing centres), induction, amniocentesis, EFM, ultrasound, episiotomy, lacerations, and more statistics that failed to answer any one of the questions posed. None of the statistics covered the period 2005-2009; instead they sent statistics from 1979-2006!

None of the questions AIMS asked was answered, despite two reminders. It is clear that Dr Waldman had no evidence whatsoever for his claim.

Beverley A Lawrence Beech

The problem with complaining

Louisa shares her reasons for not challenging the poor care she received

I recently read a journal article on the AIMS web site called 'So What's Your Problem?' by Alice Charlwood (Vol. 21 No.1) in which the author was wondering why more women don't complain about poor maternity care. I can't speak for others, but I'd like to share my reasons for not doing so.

With my first child, I had grounds for complaint over my care – I was given oxytocin without my consent without reference to the progression of my labour/strength of contractions and despite it being known my baby was breech. I was told I would on no account be allowed to birth a breech naturally on all fours but needed to do so in stirrups, with a doctor present. When I finally agreed to their constant requests that I sign a caesarean consent form, it took them an hour to find an anaesthetist.

However, though I really wanted to, and others suggested it, I did not make a complaint. I could not think about the events of her birth without feeling extremely angry and violent towards the maternity personnel, and I cried uncontrollably whenever I recalled it.

I hated the way that made me feel at a time when I was also getting so much joy and pleasure from my little girl, and I found the memories exhausting in a way that made it hard for me to look after her the way I wanted to for a few hours afterwards. It also affected her to see me upset – even as a tiny baby she reacted to me crying. Therefore, I made a conscious and determined decision to avoid thinking about her birth, and deliberately shut off the memory whenever it started to rear its ugly head.

I knew I had a year from her birth in which to make a complaint, so I revisited the idea close to her first birthday. I looked at the complaints procedure and allowed myself to think about the birth again. I discovered that I was still badly affected by the memory, and thinking about what the complaints procedure involved I realised I would not only be forced to revisit the memory many times if I initiated it, but I might also be required to face the staff I was complaining about, possibly in the building where it had occurred.

Having been to a different maternity hospital recently to visit a relative's new baby and been afflicted with a strong desire to escape, coupled with what could only be described as hatred towards the building and the staff within it, despite them never having done anything to me (or my relative) I did not feel this was something I would be able to deal effectively with. I also realised the procedure was not a quick one and was likely to leave me in a state of apprehension about various decisions at a number of points if the complaint progressed beyond the first letter, especially if it dragged on (as it was likely to do – giving drugs without consent is not taken lightly but the grey area of 'implied consent' could easily raise its ugly head.)

There was also a high likelihood that it would make no difference for the good, so the stress complaining would put on me could be the only tangible outcome from my perspective. Even after a year, I did not feel up to taking this on emotionally.

My daughter had grown into a wonderful toddler who was a source of real joy in our family and not only could I not bear the thought of what my likely emotional turmoil might do to her if I entered the complaints procedure, I also had a fear that if the complaint took over my life (as it might well do if it became a fight) and dominated my emotions I could start to see her differently, as a trigger of my memories rather than the one who made me forget them. I did not want that in any way: her wellbeing was, and is, my primary concern. So, I allowed the deadline to pass.

I reached a point where the memories did not induce an overwhelming emotional state

After four years, I reached a point where the memories did not induce an overwhelming emotional state, and we decided to have another child. The pregnancy brought back a lot of it, mostly in the form of my crying over how I had allowed my own understanding and instincts to be over-ruled, and anger on behalf of my daughter who could so easily have been damaged by the birth. I was very determined that my second birth would be different, and I wrote a long birth plan that detailed exactly how the previous birth had been conducted and how it had affected me. This affected the midwives in charge of my care and they went out of their way to support me (though I think it also helped that I was politely stubborn and proved I knew what I was talking about.)

I have never attempted to rationalise my care, though I have felt very guilty that I did nothing at the time to stop what I knew was very bad practice and needed to think about that very hard before I could stop blaming myself. I have come to terms with it as something that happened which I cannot change, and the birth of my second child, in which I was in complete control, helped a lot to curb the emotional clout of the memories, as well as improving my feelings towards midwives and the maternity building, as my care then was almost the complete opposite.

My reasons for not complaining were to ensure my own and my child's wellbeing. I did consider whether a complaint might improve things for others, but I felt my

top priority had to be my family and I could not sacrifice them for the sake of those I had not met. One year sounds like a long time, but really it was too short a deadline for me. I was simply unable to deal with recalling the birth for a good few years. I would have made a complaint when my daughter was around three had I had the opportunity, as by then time had dulled the power of the memory enough, but of course it was also no longer possible for any complaint to be officially dealt with.

I'm not even sure anyone knew of the poor care I had received

I'm not even sure anyone knew of the poor care I had received – I was the only constant in the proceedings: staff changed a lot (I'm pretty certain miscommunication on a shift change led to me being given the oxytocin, as one set of midwives had said my labour would be checked in an hour and then oxytocin considered, before they left the room; the next ones to enter were a different pair and simply administered oxytocin without examining me) and often only one staff member was present when things were said and done – so I doubt anyone other than myself was really aware of the actions of everyone else. Certainly no one appeared to think I had had any problems at the time. I learned much later that mothers who have traumatic births are sometimes offered the chance to see a maternity professional soon afterwards, to debrief their experiences. This was not something that was ever offered to me, which I conclude means I was not classed as having had a traumatic birth by hospital staff.

The birth plan I wrote for my second birth, that detailed it all for the first time, seemed to come as a shock to those who read it, including my husband, who had had no idea how I had felt after our daughter's birth as he was another who I wanted to protect from the effects of my memories, and who had a lot of influence over how I was treated the second time round.

I don't know if my birth plan had any real effect on how others might have been treated, but for me and my family in isolation I don't think an official complaint would have been anything like as effective.

Louisa

AIMS Comment from author Alice Charlwood

This is an incredibly interesting and moving response to the article I wrote, and I bet it represents the feelings of quite a lot of mothers who swallow, in this case, overwhelming feelings of distress and anger and guilt for reasons of self-preservation. Louisa comes across as an amazing, strong and capable woman, yet even she could not face pursuing what she saw as a justified complaint

even a year and more afterwards. Her story bears out some of the points I made that: (a) embarking on an official complaint may be damaging in a number of ways, not least because somehow it seems utterly at odds with the emotional attachment, joy and satisfaction these mothers are getting from their babies and family life; and (b) official complaints are unlikely to change anything for the better – Louisa thought, with hindsight, that the staff were probably oblivious to the way her first labour was mismanaged because communication was so poor between them at the time.

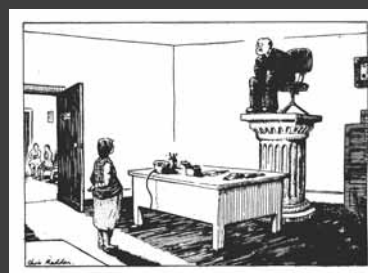
Louisa's comment that even her husband was surprised and shocked to discover the depth of her emotional turmoil when he read her birth plan, is testament to how good women can be at rescuing others from distress by hiding their true feelings. The cost to herself of doing this must have been very great, but she maintained the necessary facade for four years as she felt the cost of doing otherwise would be intolerable.

There is much for us all to learn from Louisa's account of what happened to her, and not least the way she took more control over her second birth by being, as she puts it, 'politely stubborn' and 'knowing what she was talking about'. This raised a cheer from me as I read it, and I hope it inspires others to do the same.

Alice Charlwood

Making a Complaint

Making a Complaint About Maternity Care



AIMS
ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

The complaints system might initially seem like an unfathomable maze. Making a Complaint provides guidance on how to make a complaint and follow it through.

Available from AIMS by post or via the website

Dear BBC

Holly Lyne's letter of complaint to the BBC on their portrayal of human birth

I was absolutely outraged to see and hear such terrible, inaccurate and scaremongering reporting on the topic of human birth on BBC Two's 'Origins of Us' on 31 October 2011. Not only were there grievous errors in the 'information' relayed to the viewer, but the accompanying footage of a woman in labour and the presenter's own bias following her difficult birth experience coloured the topic beyond reproach.

Some pearls from the presenter included 'Giving birth is the most painful and dangerous thing a woman can do', 'Humans are the only species that need help to give birth' and 'Even a straightforward birth is difficult'. The presenter then went on to demonstrate, with models, the passage of an infant's head through the maternal pelvis.

First of all, giving birth is not dangerous. In the vast majority of cases, when a woman is supported to birth following her instincts, the risks are minimal and outcomes are good. In our highly medicalised birth culture, birth has become more dangerous due to the unnecessary interventions inflicted upon women, the poor levels of support and the dangerous conditions under which most women are expected to birth (in hospital, with bright lights, anonymous staff, stimulation of the neocortex etc.).

When birth is left undisturbed, unrushed and private, the neocortex is not stimulated and all the necessary hormones are free to flow, making birth shorter, less painful and safer for mother and baby.

Secondly, the vast majority of women do not 'need help' to give birth. Good support from a trusted midwife, who keeps her hands to herself unless a concern arises, is all most women need. In some cases, some obstetric help is required; however, these make up the minority.

A straightforward birth may be hard work, it is called labour after all, but to state that it is difficult is misleading and scaremongering.

The footage shown may be footage of a 'typical' hospital birth in the UK, but the conditions were not optimum. The poor woman was labouring on her back, the least favourable position for birth, she had at least two midwives present, coaching her, a camera crew and bright lights. No wonder her birth was difficult! She should have been mobile, with minimal personnel present, dimmed lights and non-verbal support. Had she had this, plus good-quality antenatal preparation, her birth may well have been significantly easier and calmer.

The demonstration with the model pelvis and skull was extremely misleading and riddled with lies of omission. The presenter completely failed to mention the hormone relaxin, which is released during pregnancy and allows the pelvis to loosen. During birth, this hormone and upright or all-fours positions allow the pelvis to expand by up to 30%. Also, there was no mention of the fact that fetal

skull plates are not fused and frequently mould and overlap during birth, making the baby's head smaller. These facts in combination make it perfectly possible for the vast majority of babies to pass through the birth canal smoothly and easily.

Evolution doesn't tend to make long-term mistakes. If birth were really so difficult and so much obstetric intervention required, then the human species would have become extinct centuries ago.

Evolution doesn't tend to make long-term mistakes

This programme, on the back of the inaccurate reporting of the new NICE caesarean section guidelines, which stated that caesarean sections are now 'as safe' as vaginal birth (which is a complete lie and not what the guidelines state at all) makes for extremely dangerous and misleading reporting. Women watching and listening to the BBC over that time will have been led to believe that birth is something it is not and may negatively influence their birth choices and both their and their baby's health.

I find it very disturbing that your researchers have not come across any accurate information, or if they did they chose to omit it in favour of this inaccurate and sensationalist reporting. This is far below the standards I expect from the BBC.

May I suggest that your researchers be directed to the academic literature freely available online from such sites as www.ncbi.nlm.nih.gov/pubmed/ and reference.medscape.com/ on the subject of birth, as well as literature by Dr Michel Odent, Ina May Gaskin, Prof. Mavis Kirkham, Sheila Kitzinger, Dr Sarah Buckley, and the Association for Improvements in the Maternity Services (AIMS), among others.

I fully expect a full public apology from the BBC for your inaccurate and scaremongering reporting and a positive and informative programme to air in order to correct the inaccuracies portrayed last night.

Holly Lyne
www.airedalemums.co.uk – Making Birth Better
AIMS Social Networking Officer

The BBC responded but did not answer any of the points raised. As of compilation of this Journal, we are still awaiting a response that addresses the complaints made.

Maternal mortality in the UK

Shane Ridley explores the 'need for obstetric physicians' article in the BMJ

Most maternal deaths are now caused by preventable or treatable medical conditions. This article makes shocking reading; however, it is, at the same time, heartening to see that some doctors are willing to admit this problem. It's just a shame it didn't hit the general press with the same force.

Saving Mother's Lives (see Nadine Edwards's article on page 4) goes into detail on the *Eighth Report of the Confidential Enquiry into Maternal Deaths* (CEMD). The BMJ editorial¹ summarises that report, highlighting that most maternal deaths in the UK occur in women with pre-existing or new medical and psychological conditions, for example cardiac disease and neurological disease. One third of the cases are classified as having had major substandard care. Other medical conditions highlighted are epilepsy, diabetes, heart failure and asthma.

The point that the editorial is making is that obstetricians alone cannot reduce these deaths as they are not necessarily familiar with these problems. They need the support of physicians and general practitioners. The report from CEMD makes specific recommendations including pre-pregnancy counselling where women have pre-existing medical conditions; swift referral to specialist centres of expertise; and more training about pregnancy for those doctors who do not work directly with pregnant women (e.g. GPs).

The editorial makes the point that other surgical specialties have medical counterparts, for example in neurosurgery, urology and cardiac surgery. In practice this means that the clinical team will have access to a physician who is expert in the patient's medical condition in relation to the surgery about to be undertaken.

The editorial highlights that the success of obstetric anaesthesia led to a fall in anaesthesia-related deaths. As well as a recognition of the subspeciality of the obstetric physician, the editors are calling for obstetric medicine to be part of the postgraduate training curriculum of GPs and physicians.

Comment

I googled 'most maternal deaths are preventable' and the first item which came up was 'Maternal Mortality Rates Rising in California'.² The conclusion of this report was that the number of woman who died in the state after giving birth has nearly tripled over the past decade: *'Most women died from haemorrhage, from deep vein thrombosis or blood clots, and – this is the surprise – from underlying cardiac disease'*.

The rest of the list included reports from Sub-Saharan Africa, Ghana, China and Nigeria. Another report with similar details: Analysis of maternal mortality in a tertiary care hospital to determine causes and preventable factors³ came to the same conclusion in 2003: *'Obstetrical*

haemorrhage and hypertensive disorders are still major causes of maternal deaths. Most maternal deaths are preventable. The provision of skilled care and timely management of complications can lower maternal mortality in our setup.'

The doctors who wrote the editorial are all obstetric physicians so they are knowledgeable and convinced of the need for quality care. Why isn't their voice being heard? Why are women still dying all over the world?

'No decision about me, without me'

It may be of benefit to all women planning pregnancies that are likely to be complicated by potentially serious medical conditions to ask for pre-pregnancy counselling.

Suggestions for pregnant women who have or develop an underlying medical or psychiatric condition are to:

- Tell your midwife, GP and obstetrician and make sure that it is highlighted in your notes.
- Ask your midwife, GP and obstetrician whether they are qualified to care for you.
- If you are offered medication, or it is suggested that medication is stopped, ask questions of your midwife, GP and obstetrician BEFORE doing so, if YOU think it will compromise care of your medical condition.
- Refer to the Confidential Enquiry into Maternal Deaths recommendations if your request is queried.
- Ask for a second opinion or complain if no action is taken – your life and/or the life of your baby may be at risk.

AIMS advice to midwives and obstetricians mirrors the advice highlighted in the CEMD (see page 6) – *'listen to the woman and act on what she tells you.'*

As Andrew Lansley, Secretary of State for Health, is preaching: 'No decision about me, without me' (a reference to shared decision-making).

Shane Ridley

Reference

1. Nelson-Piercy, C, et al (2011) Maternal mortality in the UK and the need for obstetric physicians BMJ 2011; 343 doi: 10.1136/bmj.d4993
2. Snow, K and Amos, S (2010) Maternal Mortality Rates Rising in California <http://abcnews.go.com/WN/changing-life-preventing-maternal-mortality/story?id=9914009#.T2y66K54Yk8> – 4 March 2010
3. Begum S, Aziz-un-Nisa, Begum I (2003) Analysis of maternal mortality in a tertiary care hospital to determine causes and preventable factors. J Ayub Med Coll Abbottabad. 2003 Apr-Jun;15(2):49-52

Reflections on birthing

Susannah Sweetman reflects on her experiences

When I became pregnant with Evie, Mal and I had just moved back to Dublin. We had been living in the South of France, and left Toulouse in July, to go to the Caribbean and deliver a yacht back to Ireland. It was a desperately stressful trip, delayed because of problems with the boat, engine trouble, difficulties to the point where we had no option but to leave the Caribbean at the peak of the hurricane season.

My memories of the crossing are that it was in fact quite calm – we were so relieved to get away from the British Virgin Islands, and out to sea. There is something about dropping out of soundings (when it's too deep to gauge the depth) – it's like dropping off the face of the earth, or into an alternative two-dimensional universe. People ask whether it's claustrophobic, being on a boat for that long, in such a small space with three other people, but you'd be surprised: your boundaries shrink, and you don't need that much space. Things become simplified. Time is different at sea, measured out in three- or four-hour watches. Catching fish, cooking, reading, sleeping. There's less talking, and more space between people than one might imagine.

There is very little one can control in the middle of the ocean, so you have to accept the conditions. There's no going back, in September, in the Atlantic. The further north we got, the less likely we were to be hit by really bad weather, so every line of latitude was a cause for quiet celebration, acknowledged with a nod, a toast of coffee cups. We became more relaxed the closer we got to the Azores, and then to Cork. I don't think we ever thought anything terrible would happen, we were all quietly confident, but continued to worry, dutifully, superstitiously, in case something might sneak up behind while we weren't looking. With sailing, all that wind and water, you can never predict what will happen at the end. You can sink half an hour from port, or your anchor can drag when you're moored. Things can go wrong very quickly. You can never let your guard down. We arrived in the Azores almost three weeks after we left St. Maarten, with hurricane Katrina screaming across the Atlantic below us. It took another eight days at sea to get from the Azores back to Cork in very heavy seas and winds. We arrived in Baltimore in the middle of the night, accompanied by dolphins and a pod of comically friendly pilot whales. It was a huge relief to be back in Ireland. We were delighted to be home.

The reason I mention these things about sailing is because, for me, there are parallels with being pregnant. There are no half measures. Once I was pregnant, I was committed to it, and I knew that somehow I would have to come through it, and out the other side. I did worry about things, the birth, the pain, whether I would be any good at it all, but I worried more about how difficult it

was to get any straight answers from anyone about it. I recognised warning tones in the antenatal classes and from other women, my mother and my aunts, whispered lines of coded advice here and there, my mother blurting out 'oh, poor you!' before she could stop herself when I told her I was pregnant. But at the same time, I trusted myself. I felt confident. I had always been healthy. I felt strong, I had a supportive partner. I trusted my body. I really believed that I would be able to hold my own. I thought that when push (excuse the pun) came to shove I would be able for it. It was something I tried to hold onto throughout my pregnancy, but it became increasingly difficult.

I have been trying to write down my birth stories, as a frame for what emerged from them. It has been surprisingly difficult to recount my experiences of birth in a chronological way – I can't seem to remember it in that way – the camera jumps. It prioritises unexpected memories. Everything is fragmented. There is no unifying narrative, other than a steadily growing sense that I ought not to be as confident as I was, because anything could go horribly wrong at any moment, and that you aren't out of the woods until ... ever? At least until you're holding the baby. The chronology of what actually happened makes less sense to me than the ebb and flow of certainties and insecurities that accompanied the events. It is only now that I realise that it took my second experience of birth to make sense of my first.

Evie

I looked forward to the first booking appointment so much when I was pregnant with Evie: I was very naive – I think I expected to be made a fuss of, just for the fact of being pregnant. I was so disappointed by it. The atmosphere in the waiting room was dominated by a sense of mutual suspicion between the women over who was next in the queue. I sat opposite a midwife who sat behind a computer screen and fed deeply personal information into a database about me – if I had been under any illusion that I was special before I went in for that first appointment, it ended there. My disappointment (an understatement – disillusion?) turned into anxiety, which over time fed into mistrust of almost everyone I came into contact with – the scan technician, the midwives in the hospital who take your blood pressure before the appointment, the GP, the secretary of the local semi-private clinic, who seemed to have an inflated sense of control and propriety over information that was not hers, the obstetrician and his henchwomen, his registrar. Any information that I got was on a need-to-know basis only. The obstetrician galloped through the appointments. Beyond, the people whose job it was to measure and tick boxes about my size and weight. I felt there was a withholding of information from other sources – between

Malachi and I we have eleven aunts: they all have daughters, and lots of the daughters have daughters too. It's a family of women. They wouldn't tell me anything when I was pregnant – I kept trying to read in between the lines, and catch meaning in between their shared glances – I wasn't in the club yet.

The antenatal classes were a series of lectures given by a jocular midwife who laughed her way through anecdotes about bewildered new mothers struggling to cope – with labour pain, with breastfeeding, with a crying baby, with nappies.... I began to feel that the subtext to her telling these tales was to illustrate to us novices that there was nothing new in any of what was happening to us. She had seen it all before, and there was nothing special about any of it. She told us we would 'just know' when to go to hospital. I wasn't so sure I would know.

I went into labour at home. Even though I knew it was coming, it was still a shock to think that I would have a baby at the end. I rang the hospital, and the woman I spoke to said that it didn't sound like I was in labour (what, in my voice, made her think that?). I countered with my own mystic 'I just feel like I am' but that wasn't enough – the fact that I was still able to speak meant that I should stay put and ring back. An hour or so later, when I was able to speak in gasped fragments, we went to the hospital. There is something embarrassing about being in that much pain in public. There shouldn't be really, especially in a place where labour pain is part of the process, but it seemed to me that it was made embarrassing by the idea that it wasn't really acceptable to express pain. An older midwife called Mary came to examine me. Up until that point, everything was going well, and then, all of a sudden, she broke my waters during a contraction. I asked her to wait until the contraction was over, and she said 'it's alright, I'm not doing anything' – I remember feeling, thinking – I had never been so bewildered or shocked by the dislocation between what was being said and what was being done – it was like someone pointing at black and saying, insisting it was white – I simply couldn't believe what was happening.

Three or four years previously, my mother had been having chemotherapy, and once when we were talking about it she said, by way of explaining how she coped, 'I just pretend it's happening to someone else'.

I pretended it was happening to someone else. I felt that it was the only way I could deal with so much uncontrollable panic. I felt totally dislocated from myself. I felt suffocated. I was so thirsty. They wouldn't give me anything to drink. It was like being tortured. I couldn't believe what was happening. The midwife told me to save my energy for pushing. I had an epidural. Malachi was told to leave. He didn't come back for a long time. I couldn't continue without him being there. Labour stopped. I had oxytocin. It started again. The epidural wore off, but it was too late to have any more pain relief. The midwife was telling me to push and I remember thinking that I thought she must be wrong because I just didn't feel like it, that she would come out anyway, whether I pushed or not. I remember thinking there was

something vaguely melodramatic and theatrical about the whole scene, her shouting at me like a racehorse commentator. But I did push, anyway, because I thought maybe the epidural was confusing how I felt and the midwife must know something I didn't. I felt like I was acting. At one point I remember thinking that this was when a woman berates her husband for getting her into this situation – it could have been my next line. I thought that maybe the epidural had dulled my brain. They took a foot each. And then she was born. The umbilical cord was cut. It was like a cut snake. There was a spray of blood on my face and high up onto the wall behind me. Malachi's face was horrified. I don't know where they took Evie. They brought her back then. They shoved her up inside my t-shirt ('skin-to-skin!' someone bellowed) while I had stitches. I asked how many stitches – out of a bizarre sense that I ought to make conversation since no one else was – 'not many' came the reply ('too many' as it happened, an error that wasn't rectified until 9 months later). Everything about her birth was an assault – shock – brash – everything was too bright – too loud – staccato noises in the delivery suite – women screaming in adjacent rooms – midwives barking at us and each other.

people who are autistic find it hard to read other people's facial expressions, and that's how I felt

So that was that. There was something wrong with my head when I was still in the hospital – when I went to register the birth I couldn't remember Malachi's middle name. I couldn't make sense of anything they were saying – I couldn't decipher the meaning from the look on the midwives' faces when I was struggling with breastfeeding – Pity? Sympathy? I remember thinking about autism, and how people who are autistic find it hard to read other people's facial expressions, and that's how I felt. I had my perfect baby – I kept being asked 'was it a normal birth?' – when we were still in hospital, at the two-week check, the six-week check – surely it was not normal to have felt so obliterated? There had been such disparities between what had been said and what had been done, during the birth, and this now continued. On paper it had been a normal birth, healthy baby, healthy mother, nothing to report. I couldn't make sense of it.

I went to a breastfeeding group. When I began to speak to other women – it was only when I began to understand that my experience was a version of normal that things began to make sense – that is, the version of normal that passes for normal – a normal bad experience. At first I thought that a series of unfortunate events had led to me not having a good birth – the wrong people, the wrong time, bad luck, a particularly busy day at the hospital – but it was typical. If anything, Evie's birth hadn't been that bad – I hadn't been induced, I hadn't had a caesarean or a forceps delivery, or a ventouse birth. I

Readers' forum

hadn't been told that terrible things were wrong with my baby. I hadn't been told to pull myself together, or wasn't I lucky she was born alive. I was struck by how we all told our stories in the same way – there was so much fear and shock in those experiences. When I studied psychology, I was interested in issues around bereavement – when people have been through a bereavement, or any kind of a trauma, they repeat their stories in such a way that they become crystallised, so they can tell them over and over again without it really affecting them any more. It's a coping mechanism: to tell a story is to explain, without having to engage – it becomes a separate, independent entity that can be drawn on, like putting on a CD. They use the same phrases, the same pauses, intonations. Everyone does it. But to really work through something, you have to learn how to express it in a different way, and tell a different story. As the babies grew bigger, we talked less about episiotomies, mastitis, thrush, stitches, scars, blood and guts, and more about teething, sleep, feeding, weight gain. I felt like a birth veteran, along with my friends, my aunts, my mother.

Reuben

To really understand my story of Evie's birth I had to learn how to tell it in a different way. My second pregnancy was dominated by doubt and uncertainty and fear, reflected in my chaotic attempts at organising maternity care. When I became pregnant again, I was terrified – my first thought was 'I'm going to have to go through labour again'. I waited so long to book myself into anywhere that the midwife at the booking appointment asked me whether I would like to see a social worker to discuss why I had decided to conceal my pregnancy, maybe I was in denial about 'my situation' (I hadn't concealed it from anyone: I was paralysed). I thought the Domino Scheme sounded like the thing for me, by then I felt far more informed about models of care – but we were outside the catchment area. I booked myself into the semi-private clinic where I had been before, but I was determined not to be railroaded into anything this time.

I wanted to keep my options open though

I wanted to keep my options open though, and I thought that my local maternity unit might be better (or rather I thought at least women are able to drink during labour) so I booked myself in there too. The initial booking appointment was with a student midwife to whom I confessed my double booking – she said not to worry, that everyone did it. The waiting room felt like a holding pen. The women are weighed in public. It's degrading. One day, while I was waiting, a young Eastern

European woman came in alone. She was 18 weeks pregnant with twins. She was having a miscarriage. The midwife taking her details treated her so badly, humiliating her, questioning her, broadcasting her uncertain responses to the room. I realised that this was no better than the semi-private care, worse if anything. I left.

In one of our long discussions about it, Malachi suggested having a home birth. What it came down to was being somewhere safe, with someone I trusted – with someone who cared about the baby. Two of our friends had had home births – both had been transferred to hospital but they were both adamant that they would not have done anything differently. I read Anne Enright and Naomi Wolf, which was a turning point for me. Then I read Sheila Kitzinger, Ina May Gaskin, Ann Oakley. I became more confident as it began to make more sense to me.

I was 33 weeks pregnant when I rang the woman who was to become our midwife. She listened while I attempted to explain. She came to see us and stayed for two hours. I trusted her. The decision to have Reuben at home brought with it a huge number of unanticipated problems and decisions. I was so relieved to have made the decision that I'm not sure it really occurred to me we were opening such a can of worms. Responsibility was everywhere – did I really realise what I was doing, what I was getting myself into? No one seemed to have qualms about telling us we were mad. You're so brave. Would you not be worried? Will you be able to have an epidural? Would you not be afraid ...? Would you not

Blissed out, labouring on Reuben's birth day



just go ahead with it? The first time is always the worst. Just get it over with. Why would you do something so dangerous? What about all the ... mess?

Telling the obstetrician was difficult – she was pregnant too. I think she took my decision as a personal attack on her profession. It was not difficult to arouse her suspicion (I asked some questions – a dead give-away) even before I had decided, I made the mistake of seeking her opinion on home birth: 'the most important day of a baby's life is the day they are born' ... 'do you really think you'll be able to cope with the pain?' (I didn't know, was the honest answer – but the pain wasn't really what I remembered from Evie's birth – it was a distant second to thirst). She would never consider home birth because even if it only takes ten minutes to get to a hospital, those ten minutes could be the difference between life and death. She wrote down a list of different possibilities, a disclaimer. Did I understand that I was more likely to have a baby with cerebral palsy? That both the baby and I were more likely to die? I left with death ringing in my ears.

Our families were worried. They felt it was an unnecessary risk, that I was making a mountain out of a molehill. I began to gain an unlikely reputation as being stubborn and reckless, a troublemaker. Could I not just go in, find a nice doctor who would take pity on me, induce on my due date? Could you not just have the baby and then go straight home again? Magical, life-saving forces were attributed to the hospital (saving me from myself?).

Support came from unexpected places – our

Just born



neighbours were excited. Kathleen, in her nineties, was delighted. She had had all her children at home, she told me, and no babies had been born on our road for nearly fifty years. She told me about all of them – a midwife arriving on a bike in the middle of the night for one. She told Malachi to let her know if he needed her to come in during the labour. When I went to collect my file from the hospital, a clerical officer marched up and handed it to me and said 'you're dead right! You're well out of here!', and then she was gone, before I had the chance to say anything.

I felt that if anything – anything – went wrong, it would be my fault

But I felt very alone. I felt that if anything – anything – went wrong, it would be my fault. Despite wholehearted support from my midwife, and Mal's support, I was on my own. They had far more confidence in me than I had in myself. I was worried about having to go for a scan and being put under pressure to stay and be induced, as my midwife had told us might happen. I was so worried that I would have to leave my midwife at the door of the hospital, and that I would be in a worse position than I had been the first time around because they would know I had wanted to have a home birth, and would judge me for it.

And then I went into labour. Evie went to the crèche and Malachi went to work. The beginning of labour was strangely familiar to me. I did some odd things – odd in that I just did them without really thinking about it – I took off my rings. I was quite methodical. I was calm. I was taken over by it, but it never felt out of control.

I rang Malachi to tell him he should come home. I rang my midwife to tell her to come. It was about half past ten in the morning. When she arrived, she knew that things were going very quickly and that he was very close to being born. She didn't say or do very much during the labour, but I knew that she understood perfectly. It was a very fast birth, two hours, from start to finish. It all happened so quickly – it was very intense. There were what seemed like quite long, welcome breaks between the contractions at the end. I don't think there had been any breaks when Evie was born. When Reuben was born, after the immediate post-birth things were done, we sat on our bed and beamed at the baby and each other. He had a dimple. He had loads of black hair. It's hard to describe how I felt afterwards – I was elated. I felt like there was nothing I couldn't do, I felt like some kind of warrior queen. I felt completely invincible. Sometimes, looking back on it, I still do, I can draw on it. A friend collected Evie and brought her home. I was so full of energy, not just for the rest of the day, but that night, too, and the following day. At 1 in the morning I got up and

Readers' forum

had a cup of tea and a sandwich and watched everyone else sleeping. After about three days there was a bit of a crash, and I stayed in bed with Reuben – our window overlooks the canal and trees and I felt as though Spring had come during that week. I went inside during the Winter and came out in Spring. Everything seemed symbolic and loaded with meaning.

It was only in the days and weeks that followed that I talked with my midwife about the birth and began to realise how it had been such a transformative experience – it was empowering, but in ways that I had not expected. There was no fear in any of it. I still think of Reuben as being partly her baby. Everything about Reuben's birth made sense in a way that nothing around Evie's birth did. I had never expected the midwife's role to be as important as it was – I felt that she had given me back something that I didn't know I had lost.

When Reuben was born, I was in the middle of doing my MSc. I had wanted to write my thesis on birth, or women's experiences of different models of birth, but I had very little time, and I realised that what I wanted to do was beyond the scope of a masters. Instead I wrote it on women's experiences of domestic gender roles following childbirth. When I was doing the research, I interviewed several women, all of whom told me about their birth experiences. As I listened to their stories, I realised that women in maternity hospitals in Ireland consistently experience traumatic birth. They are frequently badly treated. More often than not, what matters to them is disregarded. Their concerns are not listened to, their birth plans are laughed at, their wishes to engage with their own experiences are dismissed in place of archaic hospital practices. Birth is not valued, nor are women in labour, nor is motherhood. It is normal to have a traumatic birth. It is normal for a healthy woman with a healthy baby to go into hospital and have a birth that is characterised by unnecessary, unreliable, harmful interventions and it is normal for her to struggle to make sense of it afterwards. The collateral damage associated with these types of birth has lifelong consequences.

Women talk about their birth experiences in intimate groups of three or four, in each other's houses, in coffee shops and playgrounds and at bus stops. They lean in to one another conspiratorially, comparing notes in urgent whispers, consolidating experience. They do not talk to women who have not yet had children about childbirth because there is an unwritten etiquette that it is bad form – you might frighten them. The irony is that by being complicit in the silence around birth, women themselves are contributing to a culture of maternity care which doesn't support questioning, it doesn't support or encourage exploration or discussion of issues around childbirth, it encourages compliance and passivity of women. It supports complacency and powerlessness.

The level of public discourse and the information that is in the public arena around birth is very limited. Even much of the evidence-based research is very limited, in many ways – statements like 'women want more control over their care' are oddly superficial. Yes, women do want

more control over their care, but this is often interpreted as meaning control over pain relief, being able to choose one obstetrician over another, control over specific aspects of, for example, Active Management of Labour. Birth is considered by the majority of women that I spoke to, as what you have to go through to get your baby. You must do it, and then put it behind you. For most women who go through the hospital system, it is something to be dreaded and feared – the fear isn't specific, it's just everything around birth that is frightening, or potentially frightening.

All of this, inspired by the contrast between the births of both of my children, has made me want to listen to women's stories, and to explore discourses around birth. Women's perceptions of agency and autonomy within different models of maternity care must be examined in order to make sense of the incongruities and confusion that have become a normal part of having a baby in Ireland.

It is almost impossible to see how women-centred care can be truly implemented unless the issues that affect women in real ways are addressed in a manner that enables meaningful control and engagement in birth that strengthens, rather than weakens women. For this to happen, we have to look at the things that are difficult to see and listen to the things that are difficult to hear – obscured by silence and fear, they are the issues that are difficult to quantify, and the things that we have forgotten how to talk about.

Susannah Sweetman

Day one, relaxed and enjoying motherhood



My birth story

Catherine Rennie shares her story of intervention after intervention

It is Valentine's Day when I discover I am pregnant. It is our second pregnancy. Our first ended just a few months ago with the sad loss of our baby, a missed miscarriage. We discovered the loss at fourteen weeks. My husband and I then spent two horrible nights and three anxious days in the labour ward after having attempts to induce labour and deliver our child. My labour never did start and our tiny boy was eventually delivered during an internal examination. I feel frightened and anxious about this new pregnancy. I hadn't expected to fall pregnant again so quickly. I discover that our baby's due date is exactly one year after we delivered our first wee boy.

I join a 'yoga for pregnancy' class, which is followed each week by tea and discussions about choices surrounding labour and birth. I listen week by week and begin to think about what I want. I know what I don't want. I don't want to relive the three days my husband and I spent on the labour ward a few months ago. My memory of that time is of feeling bewildered and frustrated. We had no idea what was happening, what to expect, or how long things might take. I felt anxious and vulnerable just waiting for something to happen. The ward was really busy, but we spent most of the days in the room without much contact from anyone. The midwives had lots of babies to deliver during those few days; we could hear their cries from time to time. I felt utterly helpless.

I decide I need to feel more in control this time and from the research I have done I come to realise an important part of this is avoiding an induction if at all possible. My hope is that this will also help me avoid the need for other interventions such as forceps delivery or caesarean section which might be more likely to happen if my labour is induced. I get to my due date at 40 weeks and at my antenatal check-up the suggestion of induction is made. I tell my midwife that I want to avoid it. She doesn't ask why but seems happy enough to wait and see. I am happy and I feel prepared and ready.

I eventually reach 42 weeks and 1 day pregnant. Most women are encouraged to have their labour induced before they reach two weeks past their due date. Because I have decided I don't want my labour to be induced, I have an appointment at the day assessment unit at the hospital to monitor the baby's movement and the fluid levels in my uterus to make sure it is safe to continue waiting. On the morning of the appointment at about 3am I wake up with crampy pains. They are mild and happening every 30 minutes or so. I smile, turn over and manage to get a bit more sleep. I get up at 6am excited, happy and sure now that at last our baby is going to make an appearance and in his own time!

I ring my midwife who advises me to attend the day assessment unit despite the fact that my labour seems to be beginning. Once we arrive I meet a midwife who

looks very sceptical and relatively uninterested as she hooks me up to a monitor. The midwife seems happy with the baby's movement but is evasive when I ask her about the cramps I am now experiencing at regular intervals. She assures me they are not contractions. My excitement begins to trickle away and I begin to doubt myself. The fluid levels are absolutely fine, bub's heartbeat, movements and size are perfect, I should be leaving here happy and reassured. Instead, the way I am being spoken to makes me feel like I am in the way, being ridiculous, wasting their time. No one wants to know why I don't want my labour to be induced; no one discusses the implications with me. I am simply told I must have the induction in the next couple of days. Eventually, I offer to explain a little of my reasoning to the midwife. She softens towards me a little when I tell her my story. Now she seems happy to let me have another couple of days. She performs a membrane sweep for me and seems surprised to find I am two centimetres dilated and the baby's head is lower than she first thought. She still assures me, however, that I am not having contractions. She tells me she will make another appointment for further monitoring in two days' time but she needs to clear it with my consultant first.

We wait two hours in the corridor to see a consultant. Still experiencing the cramps, I am now having to stand up every time another wave hits me. When the consultant eventually rushes us back into the day assessment ward she seems to have little time. I feel like I am being spoken to as if I am a naughty child with no idea of the significance of my decision. I am lectured for five minutes about how I must have an induction, during which time she tells me that although the monitor might show everything is fine now, it's not very sensitive and there is nothing to say that everything will still be OK tomorrow. Later I wonder, what was the point in monitoring me at all if that is the case? Obviously baby's well being is THE most important thing to me so at the end of the lecture I don't feel I can reasonably say no. I am on the verge of tears as she writes out an appointment card with the details of the induction she has booked for me in two days' time.

By the time we reach the car to go home, the pains I have been told are not contractions are starting to really increase. My consolation is that I now really think I am in early labour and feel certain I will not need that appointment for induction after all. I try my best to relax and not begin to doubt myself. I need to put my trust in my body to do what it has been designed to do.

Looking back at my antenatal experiences, it is clear that pregnancy is an emotionally trying time as well as a physically trying one. It is so important to be able to build a relationship with your midwife throughout your antenatal care to try to foster some emotional support.

Readers' forum

It would have been a huge help to me to be able to spend some time talking things through with a midwife I knew and trusted. No one was able to give me the time to help me examine the pros and cons of induction.

When we eventually get home from the hospital appointment it is 3pm and the contractions have really started in earnest. I try to eat some lunch, check my hospital bag for the 10th time and relax, trying to prepare myself for the hours ahead. By 6pm I have my TENS machine working wonders for me and my relaxation CD on loop in my earphones and I am sitting flat on the floor with my eyes shut. I have been up and moving around with the contractions but it seems to make them all merge into one, I can't tell when they stop and start so I sit and concentrate. I am managing to stay calm and relaxed, but I can't manage to eat any tea.

When I go into hospital at about 9pm the midwife in triage seems surprised to find I am 6cm dilated and I get to go up to the labour ward. I have requested to use the pool and it's quiet enough that there is no wait so we head straight up. Eventually getting into the pool is lovely, just being able to have my considerable bulk supported by the water feels brilliant and I am able to really relax between contractions. Our midwife is lovely and mostly leaves us in peace just sitting quietly when she is in the room.

Eventually, at 7am the next morning, they decide that things are moving too slowly. I have still had a tiny rim of cervix left to dilate at the last two examinations. By this point I am thoroughly high on the gas and air and I am very weepy. I feel at my most vulnerable, like I have lost all control over the situation. I have lost confidence in my body and mentally I just hand control over. The doctor examines me and recommends a syntocinon drip to speed up my labour and I just meekly nod and agree even though I had really wanted to avoid this. My midwife is kind and has a quiet chat with me. She asks me to think about pain relief because the syntocinon will make my contractions stronger. I feel thoroughly beaten by this point so I just ask her what she thinks is best. She suggests an epidural. I agree to it and now I have the feeling of just allowing events to happen, being swept along.

Epidural in place and no longer high on the gas and air, I find myself lying on the bed being monitored while they try to insert a cannula into various of my veins. It is exactly the same experience with exactly the same view of the labour room that I had during my stay one year previously when we suffered the sad loss of our first baby boy. Thankfully, during my labour until now I had managed not to relive that experience. Now I am faced with it. The dim lighting and relaxing atmosphere have been replaced by bright lights, anxiety and the very sense of lack of control that I had wanted to avoid.

I can hear our baby's heartbeat on the monitor slowing and stopping with every contraction. My heart is in my mouth waiting for it to speed back up. The doctor looks anxious. I no longer have any pain or gas and air to think about during the contractions so all I focus on is that heartbeat. The decision is made to take me to theatre

for a forceps delivery. From a lovely peaceful water birth to the bright lights and what seems like hundreds of people in the room.

My second gorgeous son is born at 9.51am 16 days after his due date. He weighs 8lbs 2oz and is the double of his Dad. He is taken into another room to be examined and his Dad goes with him. The doctor tells me they are going to give me an injection to deliver the placenta. I had really envisaged leaving this to happen naturally with lots of skin-to-skin with my baby, quietly getting to know him and letting him have his first feed. This is so far removed from what is actually happening. The surgeon then tugs and pulls for ages and I can hear that they are concerned and are struggling to deliver the placenta.

I start to get really worried about what has happened

Eventually, my husband and son come back in, I get a little cuddle and then my husband sits next to me holding the baby. They start to stitch me up and this goes on for ages. I drift in and out of sleep and the time goes on and on. I start to get really worried about what has happened. Why is it taking so long to stitch me up? How badly am I damaged? I am so anxious about how long it is taking to repair me. The theatre staff start trying to hurry the surgeon, there is a caesarean section that needs to happen in the theatre.

Nearly two hours after the birth I am eventually wheeled out of theatre. After a forceps delivery and a really scary amount of time to stitch me I have lost 1500mls of blood and I'm to go to the High Dependency Unit. There is no room on the ward so we spend 30 minutes in the corridor. My husband and I were taught in our antenatal class that immediate skin-to-skin contact is vital for successfully establishing breastfeeding and that ideally this should be uninterrupted until the baby manages to have his first breastfeed. This fact floats to my mind two hours after his birth when I am eventually able to have a skin-to-skin cuddle with my son. The midwife helps me give him his first breastfeed right there in the hospital corridor. I am anxious that he won't want to feed but he roots around eagerly and feeds for a few minutes before falling asleep.

Once I'm in the ward itself the midwife in charge of the room seems very stressed and is flapping around. She keeps popping over and telling us she is going to get this or do that and then disappearing for hours, seemingly forgetting the important task she had told us about and leaving us worrying about it not being done. She tells me she needs to wash me down and put on compression stockings but first she must measure me. She goes to get a tape for this and doesn't come back. I am on a saline drip and monitors which keep losing contact and beeping angrily but no-one comes to check them.

I am absolutely starving. I haven't eaten for 22 hours. I know that we have cereal bars in our bag and I keep asking my husband to get them for me but he won't give me one. He wants to check it's OK for me to eat. I keep on at him, I am very spaced out on all the drugs in my system and I am getting more and more agitated. Eventually he manages to catch the midwife as she dashes past and asks her what is happening. 'What do you want to happen?' she snaps in return. I start to cry. 'Look, she's getting upset now,' she accuses him.

We are left again. My husband is absolutely exhausted so I persuade him to go home, shower and have something to eat. He goes and I am alone. The water is on the table miles away, I have a catheter in and I'm still numb from the waist down so I can't move to get it. I vaguely wonder what will happen if the baby cries. He is still sleeping peacefully in his crib.

Eventually the baby awakens and someone hands him to me and dashes off again. I am still numb, I have a drip in my left hand, wires for monitors sticking to my arms and a heart rate monitor clipped to my right hand. I am so nervous of holding this tiny baby and I can barely move him around. He is rooting around, looking for my breast but he's hard to manoeuvre there. I try but I don't know what to do. I know how well he did at his first feed so I know he can do it, I just need some help. He starts to cry. He is so tiny and red with angry-looking forceps marks. He looks so frustrated. He must be making a lot of noise as the midwife appears. I ask for help to latch him on but she seems to think I am trying to force him to feed. I don't understand it as he was clearly rooting around looking for milk. 'You'll put him off the breast all together if you force him,' she tells me. 'Just give him a skin-to-skin cuddle.' She places him directly on my chest and dashes off again. She must have been with me for all of two minutes. I drift off to sleep with the wee man cuddled up on my chest. I wake up and he is still there. It is boiling hot and we are both sweating. I am still quite numb and covered in wires. It occurs to me in my befuddled state that it is probably not very safe for my baby to be on top of me while I am asleep. I manage to manoeuvre him onto the bed beside me and drift in and out of my very woozy sleep.

Bubs is crying again. I try again to feed him but I'm having the same problem with the drip etc. He latches on briefly and then I struggle to support him and he comes off again. I try propping him up on cushions but without success. The midwife dashes past halfway up the ward and shouts over, 'that's a terrible position you know,' but does not come over to help or offer any suggestions. He gets more and more upset and cries louder and louder. I can barely move to soothe him and I have no idea what to do. The noise brings the midwife dashing past again. 'He's very red,' she says. 'He might be jaundiced. I'll need to go and get the doctor.' And off she goes again. 'Of course he's red,' I think, 'he's boiling and screaming, who wouldn't be red?' Needless to say, the doctor never arrives.

The shifts change and a new midwife is on. This one is a little calmer but just as stretched. Bubs is rooting again,

and again I try to feed him but he's way too upset and I'm way too upset now. The new midwife comes over and is very forceful and tries to latch him on but he is screaming too much. She asks when he last fed. I know it was just before I came into the ward but I have no idea what time it is now or how long I've been here for. He is given some formula by syringe and he calms down and goes to sleep. Two hours later she brings him to me again and tries to get him to latch onto my breast. He doesn't really wake up. She gives him more formula by syringe and writes on my feeding chart 'not interested in breast'.

Eventually we get out of the hell that is the HDU and moved up to the postnatal ward. My husband is back by this time and when we arrive it is nearly time for lights out and the Dads to go home. I feel sick at the thought of a whole night on my own here. I count the minutes until he comes back and get very little sleep. Bubs feeds once through the night, latches on with a little help and seems to feed. One night-time feed doesn't seem very much to me and he doesn't seem very interested. We were told in the antenatal classes that once a baby has been given formula his stomach swells and he loses interest in breastfeeding. I am losing confidence that we will ever manage to establish feeding.

My mental wellbeing is further knocked the following day when the wee man is sick and the paediatrician decides he needs to go into the neonatal ward as they are concerned it is bilious vomiting. He is taken away and I am in pieces. I feel awful, I have lost lots of blood, had very little sleep and very little to eat over the past two days and now they are taking my tiny baby away. I am very weepy. My husband and I go down with him. It is

Most of what they say washes over my head

the first time I have been out of bed since the birth.

The neonatal nurse and paediatrician talk to us when we arrive. Most of what they say washes over my head except for the fact that they are about to put a tube down our son's nose and take X-rays. They tell me he may get very distressed during this and that we might prefer not to be there while it happens. In any case I don't feel physically strong enough to stay and as my husband and I make our way back up to the postnatal ward I faint in the corridor.

The next two or three days are desperate. Bub's tests come back clear and they are happy that there is nothing wrong but they want to keep him in to monitor him. I am still desperate to breastfeed and I attempt to do so a couple of times in the neonatal ward but I don't feel strong enough to go down very often or for very long. I try and try to hand express with no success at all. I begin

to feel more and more detached from our tiny boy and I feel guilty for not going down to see him frequently. I also feel I need my husband with me but I am so aware that I am keeping him away from the neonatal ward and our son's bedside by having him with me. I spend most of my time in tears. Everyone keeps telling me that it's

staff in the postnatal ward are clearly very stretched

normal to feel weepy due to my hormones, as if my hormones are the only reason I might be crying.

When our baby is four days old he eventually comes back up to the postnatal ward with me. I am elated to have him back. They have given me my own room and I have been given a blood transfusion. I am eventually starting to feel a bit stronger. I now begin the fight in earnest to establish breastfeeding. My milk seems to have eventually come in now that I'm much less anaemic. Each time I try to feed him I press the buzzer for help. I need all the reassurance I can get. This, however, seems to make things more difficult due to the huge variety of opinions and advice given by the numerous staff members I speak to, (midwives, care assistants, nursery nurses, ladies who bring the tea, students...) I have a different plan of action with every shift change, ranging from desperately trying to express for hours on end to watching one midwife bottlefeed my baby whilst being told I am too tired to feed him myself and I should just go to sleep. The staff in the postnatal ward are clearly very stretched. I really begin to feel like my constant questions and need for reassurance are a burden to them. It takes me another three days to even think about being able to go home. I have spent my first week as a mother feeling miserable and anxious, my confidence undermined with every staff changeover.

Looking back on my postnatal care in the hospital, I am struck by how drastically understaffed they are. The High Dependency ward is my biggest concern. It is a place where new families end up when they are very vulnerable both physically and emotionally. Surely the staff there need to be especially mindful of that. A few minutes when we first arrived to explain what was happening and reassure myself and my husband would have made all the difference. The need for proper breastfeeding support here is also huge. It is surely here that mums will need a bit more physical help and emotional support with this.

The main issue on the postnatal ward is the lack of consistency throughout the different levels of staff. A consistency of advice from all the staff and I might have got home one or two days earlier.

Catherine Rennie

Dr Ágnes Geréb – Hungarian state injustice continues

Last year, our International Witch Hunt journal featured the continued persecution of Dr Ágnes Geréb, an internationally recognised, superb, midwifery practitioner in Hungary. She was sentenced to two years' imprisonment on trumped-up charges following the unexpected birth of a baby at her antenatal clinic. She subsequently appealed. Her appeal has been dismissed and further sanctions have been imposed.

The Hungarians who are campaigning on behalf of Ágnes now ask that we add our voices to their campaign by writing to the Hungarian President asking him to give her full presidential clemency and to cancel all criminal proceedings against her. They believe that this will be the first step in their continuing campaign for justice. Suggested letter as follows:

Dear President Schmitt

On 10 February 2012, the Budapest Appeal Court announced the verdict in the case of Dr Ágnes Geréb and four other Hungarian midwives. The terms of Ágnes Geréb's sentence of two years' imprisonment were tightened, a ban on practising doubled to ten years.

We believe the sentence to be surprisingly and unnecessarily severe. We also happily received the news that Parliamentary representatives of your party wrote open letters to request a full presidential pardon for Dr Geréb. We would like to join them in asking for full clemency in the case of Ágnes Geréb and for cancellation of the verdict against the other midwife convicted with her.

Dr Ágnes Geréb is an internationally renowned obstetrician-midwife who was the first in Hungary to let fathers into the labour ward, therefore allowing families to experience the miracle of birth together. She has assisted several thousand normal births without complications, and facilitated the beginning of numerous happy lives. We are convinced that her work and experience prove indispensable for the establishment of safe and good midwifery practice in Hungary.

We appreciate the efforts of the present Hungarian government to bring about home birth legislation; however, the criminal proceedings against Dr Geréb and other midwives started before the implementation of the new regulations.

Please consider it within your competency to exercise your right to provide full presidential clemency for Dr Ágnes Geréb and cancel all criminal proceedings against her.

Yours sincerely

To: Dr Pál Schmitt, 1536 Budapest, Pf. 227, Hungary.
email: ugyfelkapu@keh.hu copy to: Birth House
Association gabi.nagy@szuleteshaz.hu For further
information see: www.aims.org.uk/

I would have just gone quietly ...

Holly Lyne shares her birth and complaint story

Nearly three years ago my first child was born. I planned a home birth and felt I was really prepared for an amazing experience. I didn't hire a doula because I, naively, believed that, being as prepared as I was and as well informed as I was, I wouldn't need one.

I was wrong.

My son's birth ended up being in theatre by caesarean section at Bradford Royal Infirmary for 'failure to progress', despite the fact that I clearly stated on my birth preferences that I would not consent to a caesarean for this reason. I also stated that I would not consent to amniotomy or vaginal examinations unless medically indicated.

When my community midwife arrived at my home we were both thrilled; she had been almost as excited about my birth plans as I was and I was so happy that she was going to be with me through it. However, almost the first thing out of her mouth was, 'I know you said in your birth plan that you don't want internals, but we have to do one every four hours.' I groaned in response and then consented. I believed I did not have a choice.

The very first examination suggested that my baby was malpositioned, he was facing my right hip. Did my midwife encourage me to stay mobile? Only vaguely. Did she suggest that I climb the stairs sideways? Nope. Did she suggest I perform figure of eight with my hips on my birth ball? No.

She allowed me to labour hard with virtually no support all day, all the while desperate for the relief of my birth pool, which I was told I was 'not allowed' to get into yet as I wasn't yet in active labour. I completely forgot about the TENS machine I had borrowed and, despite walking in circuits around my house for hours on end, my baby remained persistently OT and I became increasingly exhausted, as from the very first contraction at 6am, they were at least every five minutes and intense enough for me to not be able to speak through them.

I count that very long latent phase as labour. It still counts, it was still hard work and it should have been performing an important function – to get my baby into a good position and get my body ready to birth him.

My 'amazing' community midwife finished her shift and left me with the on-call midwife, whom I had never met before. It was only days after the birth that I found out that this new midwife had only ever attended one home birth before.

I finally reached the golden '4cm' at about 9pm, after about 15 hours of contractions. My amniotic sac was still intact and I hadn't even had a show.

I was 'allowed' to labour in my pool, though the lack of a waterproof sonicaid meant that I was frequently told to

stand up or get into uncomfortable positions for the midwife to listen to my baby's heart rate.

After several hours in the pool I asked for the entonox and began to feel the urge to push. Everyone started to get excited and we all believed that we would be meeting the baby soon. It didn't seem unreasonable to me that I might have gone from 4 to 10 cm in 5 hours, except for the fact that the midwives knew that my baby was malpositioned. Should they have taken that into consideration?

Then came the moment that changed everything. The midwife told me that she 'had to' do another routine internal and that I needed to get out of the pool.

Who knows if this disrupted what was genuinely the second stage or not, but I struggled to my bed and was examined only to be told that I was still only 4cm, after several hours. I know now that it is possible that my cervix could have closed up at the intrusion, but I think it is more likely that I had a premature pushing urge due to the baby being malpositioned. Either way, this examination changed the entire course of my labour. It was disheartening, to say the least, to have made so little progress despite all of the hard work and it was so easy for me to say yes when she offered to break my waters.

I had no one there to remind me that I didn't want that intervention, no one to remind me of the risks, because you can bet your life that the midwife didn't bother to cover them.

When her face fell I knew what she was going to say, meconium. I was prepared for this one. I was over 42 weeks and I knew that thin meconium staining was not something to worry about and I told her this. I stood my ground when she insisted we transfer. I stood my ground when she scurried from the room to call her supervisor for advice. I stood my ground when she told me that my baby's heart rate had been slightly elevated for the last few readings – I wonder why she didn't mention this right away? I insisted that her and the second midwife, who had been there in the background throughout the night, monitor the heart rate more frequently for a while.

But I couldn't keep standing my ground when she turned to my husband and said 'She is putting your baby's life in danger, we need to take her in.'

When I saw his reaction, and that of my mother, who was also in the room, what else could I do?

From this point on, it's a familiar story. The torturous ride in the ambulance ramping up my adrenaline levels, halting labour. Pushy labour ward staff who tried to insert a routine cannula and give me an epidural without my consent (my husband physically stood between me and the pushy doctor to stop her from proceeding against my will), being repeatedly, but subtly, told how useless my

Readers' forum

body was and that I 'needed' their help.

The midwife who cared for us for most of the day and stayed on after the end of her shift in order to come to theatre with us, made us believe that she was on our side. We had a good rapport and I trusted her. She actually criticised the decision to break my waters, stating that she wouldn't have done that at 4cm.

But she was one of the people persuading us that my body wasn't up to the task and, lo and behold, 12 hours after arriving at hospital I was signing the consent form for surgery.

They deliberately ground me down, crushed my belief in myself and my baby, threatened my husband, made us afraid and manipulated us to believe that we were giving informed consent to every intervention under the sun, when really they had decided on the course my labour would take as soon as we arrived and were just nudging me along the path they wanted me to take.

I got a copy of my notes a few months later. There is a wonderful page in there, written by the midwife who took over our care when we arrived at hospital, stating that 'I also explained to Holly and Andrew that I am in no way coersing [sic] them into anything they do not want'. It doesn't take a genius to read between those lines. Obviously myself and my husband expressed concerns to her that we were being manipulated and she denied it, then promptly wrote that line in my notes to cover herself. She soon went off shift and handed us over to the 'nice' midwife who was so 'helpful'.

In the cold hard light of day, when I was struggling to breastfeed my sleepy son who didn't feel like he was mine, I slowly came to realise what they had done to us.

So I initiated the complaints process.

I got the standard reply; the letter said that they were 'sorry that [I felt] that way' and that they understood how 'disappointing' the birth must have been for me. They informed me that they had gone over my notes and that everything they did was correct according to their protocols. Well that's all right then.

I wrote back and told them that this 'apology' wasn't good enough, that they couldn't apologise for my feelings, only for what they had done, and that I wasn't going away until I got that genuine apology. That is really all I wanted and I reassured them of this; I stated that I had no intention of taking legal action: after all, no actual, measurable harm had come to me or my baby [sic] so no court would hear the case anyway.

After a few more unsatisfactory letters from the hospital, who finally admitted their position – that as my baby was malpositioned there was no way he would have been born vaginally – I took it to the Health Services Ombudsman, who, predictably, took the hospital's side in the matter. The hospital didn't do anything wrong, according to my notes.

In my final letter to the hospital I stated that their assertion that a vaginal birth would have been impossible was a self-fulfilling prophecy, that by the staff having that

attitude I was correct in stating that I was not fully supported to give birth. They knew that unless my baby moved I would end up in theatre and they did nothing to help me get him to move; they simply pushed me down the path to surgery. I also made the point of letting the hospital know about the Cochrane Review that states '*Routine amniotomy is not recommended for normally progressing labours or in labours which have become prolonged*', but I never got a response to that letter.

If they had just apologised I would have just walked away.

But they didn't.

So I joined a campaign group, Airedale Mums, to try to help make sure that this abuse stops and I told my story to the press, a lot.

The heart of my complaint has always been that aside from the emotional blackmail and attempts to assault me, it was the very protocols that they hide behind that led me to my caesarean section. Routine vaginal examinations are pointless at the best of times, but when the information gathered from them isn't even acted upon then what is the point at all? Medical procedures to speed up labour have no place in most births and should absolutely be kept out of the home. If my midwives had kept their hands out of me and encouraged me when my labour was long, instead of offering inappropriate interventions, then my birth story and early motherhood may have been dramatically different.

I would like to acknowledge that in the last three years, great improvements have been made at Bradford Royal Infirmary thanks to the efforts of Consultant Midwife, Alison Brown, and her senior colleagues. Normal birth is high on the agenda. Their induction and caesarean section rates have come down and they are developing a new midwife-led unit.

My second baby was born by repeat caesarean on 28 January this year. I chose to hire an independent midwife and plan a home birth; however when the birth needed help we transferred to Bradford Royal Infirmary. The staff at BRI were extremely respectful of my wishes and facilitated a lotus caesarean birth with very few reservations expressed. I'd like to thank the NHS team for their care and I acknowledge just how far the unit has come since my first son's birth. I trust that women without the watchful care of an independent midwife also receive the same standard of care from the staff at BRI.

Holly B. Lyne

The AIMS committee would like to extend huge congratulations to our Social Networking Officer, Holly, and her family Andy, Jack and Alfie. We were delighted to hear that care during Alfie's birth was a vast improvement on her previous experience. We wish Holly and her family well.

Birthing identical twins

Robyn Hall shares her journey of pregnancy with identical twins

As I was sitting in the waiting room for my 12 week scan I faced a poster advertising our local twins group and thought 'that's someone else's life', so shocked doesn't quite cover how I felt when I saw two little heads on the screen.

That's when I stopped being a mum-to-be and started being 'twin pregnancy' and 'high risk'.

I was told I would be attending the twins clinic but not told why, or given any real information, or even asked how I felt about having twins. Early on I was told that our identical twins would likely be early and, if not, that they should be delivered by 36 weeks and that I could have an elective section if I wanted or I'd be induced, but that most twins are delivered by section so I might as well consider it. I was devastated that my babies' right to choose when and how to be born was gone because they were twins.

When I kicked up a fuss I was told by the doctors that studies show twins stillbirth rate doubled if the pregnancy went past 38 weeks and twins should always be induced early. However, they did not point out that this stillbirth rate is still tiny, only a few per thousand, a tiny percentage. I asked the head midwife if there were other studies that said differently, she said no, but that was a lie. As I was being given so little information, I decided to find out for myself. The two big, healthy and very active babies I was incubating seemed quite comfortable, with no intention of coming early, so the decisions were now mine to make.

The studies I found initially said that if twins were born spontaneously at 38 weeks they fare better than later births, but that the risks of continuing the pregnancy past 38 weeks were much smaller than the risks of induction. Then I found a study that said that, contrary to standard medical advice, twin pregnancies that went past 39 weeks had lower rates of stillbirth, growth restriction and no incidences of respiratory problems at all.

As my pregnancy continued I felt under more and more pressure to follow the doctors' preferences. Every time I attended the twins clinic, people seemed to comment on my reluctance to interfere with nature. 'Have they not delivered you yet?' and 'You'll be getting a section then' from administrative staff and nurses/midwives and one narcissistic male consultant who kept on commenting on my exhausted state and then pouncing with 'have you changed your mind yet'.

Luckily one female doctor and midwife were supportive. As my two were identical, there was also the risk of twin-to-twin transfusion syndrome (TTTS) during labour. When I contacted the TTTS Foundation to ask about these risks they said there was no research indicating percentages of this or the outcomes, but that if I felt concerned I could request continuous monitoring during

labour, no mention of the word 'section', let alone 'elective'.

My girls continued to grow and were always healthy but once I hit the 39 week mark I was not. I was so uncomfortable that if an elective delivery had only posed risks to myself I would have jumped at the chance, but the idea of risking my babies with no valid medical reason was out of the question.

I ended up in hospital exhausted, anaemic and with rising blood pressure and protein in my urine. My blood tests showed I did not have pre-eclampsia but the doctors did not want to risk waiting as pre-eclampsia can come on very suddenly with twins. I had no problem with the idea of medical intervention for medical reasons but, as the situation was not immediate, I negotiated to have a little time to try natural methods first.

The day I was scheduled to be induced, after three sweeps and three courses of acupuncture, I went into labour myself. It was a long labour and due to maternal exhaustion I ended up in theatre with my first daughter delivered by forceps and my second an assisted breech.

The whole time I was monitored, there was never a concern about the babies and I'm confident this was because they had been allowed their own time to grow and develop.

At 40 weeks and three days Ella was born weighing 8lb 4 and smiled up at me from her Dad's arms as I birthed her sister. Cassidy was 7lb 13 and needed a puff of oxygen before being given to me, and both my daughters went straight through to recovery with me and fed well shortly thereafter.

I was so thrilled that they were not taken to NICU and therefore did not miss the opportunity to bond and establish breastfeeding.

Yes, twin pregnancies and births carry higher rates of many problems and sometimes interventions are necessary, but that does not mean that all twins are better off being manipulated into this world. There are lots of valid reasons to deliver twins early but, as with any pregnancy, risks should be calculated on an individual basis and the risks of elective sections not minimised, especially the risks to the babies. Twin mothers should be supported in making decisions that they know to be in the children's best interest.

When I look at my beautiful, big, strong, healthy, alert and happy baby girls, I am so proud I refused to be bullied into robbing them of 4 weeks and 3 days of growth and brain and lung development and I'm very grateful for the supportive midwives and doctors we came across and our amazing doula who all helped make our birth possible.

Robyn Hall

Reviews

Midwives Coping with Loss and Grief: Stillbirth, Professional and Personal Losses

By Doreen Kenworthy & Mavis Kirkham

Radcliffe Publishing London 2011

ISBN-13: 978-1846193880

£24.99

Just when you think that everything that needs to be written about loss in childbearing has been written, you find yourself reading a book like this one. And in many ways it is a very welcome and refreshing revelation.

The opening self-introductions by the two authors, though, create a feeling of 'Oh dear, this is going to be a sorrowful read.' But it is not long before you realise that this personal information is crucial for the reader to know from where Doreen and Mavis are coming. These sad self-introductions mean that the reader is better able to understand the authors' views on the multiplicity of vital issues which this book and topic raise.

This book comprises, effectively, a research report. That said, it is worlds away from the standard dry-as-dust account of a research project. The authors provide, as part of the findings, a wealth of graphic illustrations of precisely what happened at the interviews. The reader feels privileged to be a fly on the wall during these highly emotive yet painfully insightful interactions.

In many ways this book is a good read to the extent that some of the material is highly reassuring. An excellent, though possibly unfortunate, example is found in the inability of midwives to compartmentalise their midwifery practice from other aspects of their lives. This inability means that the feelings which midwives express about loss in their practice are all too genuine.

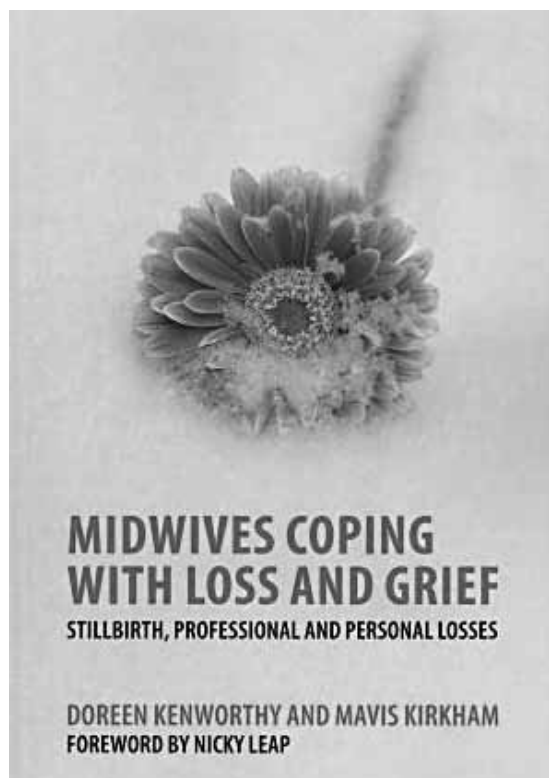
The exception to this observation of reassurance is found in Chapter Nine in which Mavis reports on a small series of in-depth interviews which she undertook with independent midwives (IMs). Some of the IMs had been through disciplinary procedures and the associated trauma. I have to suggest that it is time for a researcher to investigate this experience because, largely due to the statutory body's witch-hunt for independent midwives, such scenarios are not that uncommon.

For me, an equally difficult finding related to Doreen's work on the allocation of midwives to provide care for bereaved women or couples. The data showed that the midwife managers took little account of the experience or the emotional robustness of the midwife at the time of the allocation. The phrases 'it's your turn now' and 'passing the buck' were used to describe the managers' decision making. While such staff allocation would clearly be hard for the midwife, it is equally difficult to be certain that a vulnerable or otherwise challenged midwife would be able to provide anywhere near optimal care for the grieving woman or couple. This form of allocation may resonate with other midwives, but I know to my cost that

sometimes in such circumstances staff allocations do not necessarily have the welfare of the woman as the prime concern.

This book is an important contribution to the literature on loss in childbearing. It provides a welcome opportunity for midwives to reflect on their practice.

Rosemary Mander



Birth Pain: Power to Transform

By Verena Schmid

Fresh Heart Publishing UK 2011

ISBN-13: 978-1906619213

£15.00

Verena, an Italian mother and midwife, who started her own practice and her own midwifery school, and has written and spoken widely, here challenges the pain taboo of childbirth.

She does it in two ways. On the one hand she challenges the movement that says childbirth should not be painful and we should only use words such as sensations, surges and rushes, by acknowledging the existence of pain in childbirth and deliberately using the word. On the other hand she challenges the medical pathological approach to the pain of childbirth by asserting its necessity in a normal physiological birth, indeed asserting its transformative and orgasmic qualities. I really enjoyed the discomfort of being challenged in this way, and certainly the knowledge and philosophy that

permeate the book made me re-examine attitudes and knowledge I have long held.

Chapter 1 introduces the author's deeply spiritual and emotionally intelligent approach to the pain of childbirth and what that might mean. The second chapter dives headlong into a full description of the physiology of pain, including a full explanation of the gateway theory and brain function, and an exploration of the psychology of pain in childbirth. The third chapter examines caesarean section as the solution to pain, discussing the nature of fear of pain and how caesareans do and do not solve the problem, whilst giving sound advice on how to make a caesarean work for you and baby.

Chapter 4 examines pharmaceutical solutions to pain – and looks at how they all fail the three-fold test of being harmless to mother and baby, of being effective, whilst also not affecting the progress of a normal physiological birth. Chapter 5 looks at non-pharmacological forms of pain relief or natural pain relief – covering massage, hypnotherapy, acupuncture, birth companions, inner resources etc., but notably omitting the use of water. Natural pain relief, Schmid believes, does not numb pain but enhances the flow of endomorphins, strengthens the woman inwardly and enables acceptance.

Chapter 6 is a sort of practical workbook of how women can work through the information they have just read and find their own path through the battle of childbirth. This includes everything from ideas lists to antenatal classes, to birth care guides to postures and exercises to try. Chapter 7 is a short summary chapter which starts with the essence of Schmid's philosophy of birth as an opening up – opening up to the baby and the new role you have as a mother – with acceptance, the path is easy; if you struggle with opening yourself up, then birth itself will reflect that struggle.

Finally the role of the midwife and the importance of finding the right people to share the birth journey are emphasised: 'Cherish this process' she says, as the opportunities to go through it many times are limited.

In some ways this book at its heart is a textbook for professionals

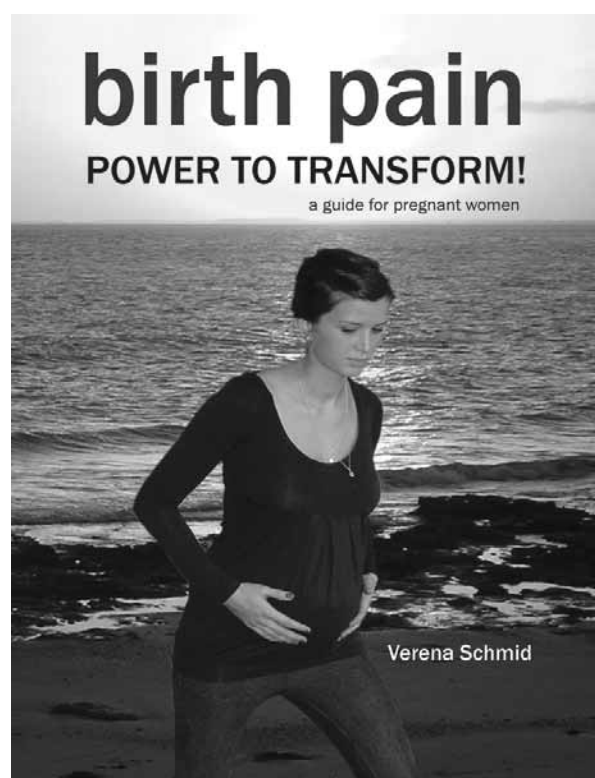
My only key concern with this book is that whilst it is addressed to the mother, the information and the manner of its delivery seem more suitable for professionals, in the view of this well-informed but not medically trained reader. In some ways this book, at its heart, is a textbook for professionals – both midwives and childbirth educators; if it were truly written to address the woman it would need to take it more slowly and go easier on the medical and anatomy and physiology side. For the non-specialist, chapter 2 was particularly difficult, with solid text, and no diagrams, notes or summaries to help the reader navigate new territory. Because of this, readers could miss some real gems such as this towards the end of chapter 2:

'during a natural physiological birth, the verbal expression of pain usually increases, and the need to move around will continue to encourage you to be active during contractions. As a result, to outside observers the pain will often seem unbearable, while in reality your actual perception of pain is reduced ... many women later report they mostly had feelings of overwhelming strength or of intense effort. Their pain had therefore already transmuted into something else.' (p28)

On the other hand, chapters 5 and 6 give a really good workbook for exploring and resolving the pain issue, and chapter 3 gives good advice for women choosing a caesarean section.

The author's passion for normal physiological birth shines through the book but it is unflinching in confronting the greatest hurdle modern western women face in childbirth. She looks at it from many different angles, reflecting on why women turn to caesarean section as a solution, or seek pharmacological pain relief, challenging both women and professionals about the efficacy and health of these 'solutions' to pain, whilst supporting women who do choose these paths with practical information. Although she argues on an intellectual level, it is clear that in her view the solution to pain is on the spiritual, instinctual and emotional levels – women transform pain from suffering to ecstasy by their acceptance of pain; by working with their pain, opening themselves up on every level, they are rewarded by a cocktail of hormones that make the experience a wonderful life-landmark of love and joy. It is this philosophy that permeates the book and puts it on the shelf of the midwife rather than the clinician. The purpose of natural pain relief is not to block the sensations but to enable women to accept and transform them.

Ruth Weston



Letters

Obstetric Failure

Over the years in the AIMS Journal I have read many appalling accounts of ill-treatment, with Emmy Lomas's account (Vol. 3 No. 2, 2011) one of the most recent. With the exception of a few medical complications, if a mother has not had the sort of birth she wanted, it is the obstetrician who has FAILED to give her that. Obstetricians have FAILED to prevent distress. Obstetricians have FAILED to research or evaluate the dangers of their interventions and routine procedures. AIMS has rightly questioned these procedures over the years and research, e.g. into ultrasound, is well overdue. (Fortunately, when I had my three children at home – 1980, 1981 and 1984 – scanning was not even mentioned to me and so I did not even have to refuse it.) Also read what Marjorie Tew has to say about obstetricians' cunning dominance in her book *Safer Childbirth: a critical history of maternity care*.

To turn to lighter things, in the previous Journal (Vol. 23 No. 1, 2011), there was a letter from Wendy Pagler about a TV series' fictional birth. There have also been a few series on television which have had an episode featuring births NOT in a maternity ward:

Men Behaving Badly – one of the episodes includes a home birth.

The Vicar of Dibley – Alice gave birth on stage as part of a nativity play, with the audience saying it was very realistic.

EastEnders – Bianca gave birth in the Queen Vic pub.

an episode featuring births NOT in a maternity ward

I think there was an episode of Casualty a few years ago which included a home birth.

I was glad to see the ancient right to mine coal in the Forest of Dean for those born in the Hundred of St. Briavels (i.e. they need to be born at home) being mentioned in the series Great Railway Journeys on BBC2 on 18th January. The miner interviewed said they had the highest rate of home births there. Do they?

I found the whole Journal (Vol. 23 No. 4) inspiring, especially the articles on breech birth at home and twin birth at home. The article on 'Undisturbed birth' was excellent and thought-provoking and the article re overdue dates great. I arrived 24 days late, at home, of course. My husband was born about two weeks after his due date, but my own three children, born at home in the 1980s, all came before their due dates.

Keep up the good work.

Diana Beamish

Obstetric Failure

Dear AIMS

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

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

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

Sarah

AIMS AGM

Saturday 14 July 2012
10:00am for 10:30am start
Carrs Lane Church Centre,
Carrs Lane, Birmingham B4 7SX
www.carrslane.co.uk

- 10:00 Tea and coffee (which will be available all day)
- 10:30 Committee business – chance to meet the committee
- 12:30 Lunch (please bring a contribution for a shared lunch)
- 13:30 Dr Mary Stewart *midwife, educationalist and researcher:*
Birthplace Study Report
- Discussion: Midwifery-led Care
- 16:00 Finish

Please reply to secretary@aims.org.uk

AIMS Journal: A quarterly publication spearheading discussions on change and development in the maternity services, this is 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

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 them. Invaluable for expectant mothers and professionals alike. See AIMS website www.aims.org.uk

Birth **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: AIMS has replaced Choosing a Home Birth with this 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

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

AIMS Envelope Labels: Sticky labels for reusing envelopes

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

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

10 Book Bundle	£50.00
----------------	--------

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

- Am I Allowed?
- Birth after Caesarean
- Bir thing Your Baby: Second Stage
- Bir thing Your Placenta: The Third Stage
- Breech Birth: What Are My Options?
- Induction: Do I Really Need It?
- Making a Complaint about Maternity Care
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

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

This book bundle contains 7 AIMS publications at a discounted price, an excellent gift for a newly pregnant friend or relative.

- Am I Allowed?
- Induction: Do I Really Need It?
- Making a Complaint about Maternity Care
- Safety in Childbirth
- Ultrasound? Unsound!
- Vitamin K and the Newborn
- What's Right for Me?

A large selection of the booklets and books are available to order from our website via PayPal

(Please print clearly in block capitals)

[illegible]

Name

Title

Address

.....

..... Postcode

Your email address

Are you an AIMS Member? Yes / No

Send cheque/postal order payable to AIMS to: Shane Ridley
Flat 56 Charmouth Court, Fairfield Park, Lyme Regis, DT7 3DS

Noticeboard

Human Rights in Childbirth

31 May – 1 June 2012

The Hague, Holland

Speakers include:

Susan Bewley, Becky Reed,

Jo Murphy-Lawless,

Elizabeth Prochaska

www.bynkershoek.eu

Contact Hermine Hayes Klein

31 6 34490423

conference@bykershoek.eu

Royal Society of Medicine Maternity and the Newborn Forum

How working with women
and their families improves
the maternity services

Thursday 16 June 2012

www.rsm.ac.uk/maternity

AIMS Meetings

Future meeting dates:

30 March - London

12 May - Powys, S.Wales

15 June - Leeds

14 July AGM - Birmingham

Please contact Gina

Lowdon for details of

times and venues.

01256 704871 after 6pm and

weekends

gina.lowdon@aims.org.uk

AIMS AGM

Saturday 14 July 2010,

10am

Carrs Lane Church Centre

Birmingham

www.carrslane.co.uk

Guest Speaker: Dr Mary
Stewart, midwife,
educationalist and
researcher

Birthplace Study Report

Discussion: Midwifery-led
Care

contact

secretary@aims.org.uk

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

MEMBERSHIP FORM

Last name First name Title

Address

.....

Postcode email:

Tel: (home) (work) Fax:

If new member, how did you hear about AIMS?

Occupation:.....

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

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

☐ £25 AIMS membership UK and Europe (including AIMS Journal) ☐ £25 AIMS Journal (UK and Europe only)

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

☐ £30 Groups and institutions ☐ £30 International members (outside Europe) ☐ £_____ Donation, with thanks

Complete and send to: Glenys Rowlands, 8 Cradoc Road, Brecon, Powys LD3 9LG