AIMS JOURNAL

VOL 22 NO 1 2010

ASSOCIATION FOR IMPROVEMENTS IN THE MATERNITY SERVICES

Is anyone listening?

The Albany - gold standard or liability?

On what are they being judged?

contents

Cover Picture: Reclaiming Birth Rally - 7th March 2010
© Max Chippington Derrick

VOL:22 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 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.

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)
Fax: 0208 390 4381
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
Margaret Jowitt
Tel: 01983 853472
email: treasurer@aims.org.uk

Hon Publications Secretary
Shane Ridley
Manor Barn, Thurloxton, Taunton, Somerset, TA2 8RH
email: publications@aims.org.uk
Note: Orders by post or website only

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

Northern Ireland Network: position vacant

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

North West England Network: Elizabeth Key
email: elizabeth.key@aims.org.uk

Founded by Sally Willington 1931 - 2008

Midwifery – who cares what women want?

Beverley Beech looks at when 'informed consent' becomes bullying

Bullying in midwifery is not new, mothers and midwives are bullied in various settings, and examination of old AIMS journals reveals numerous stories of bullying:

'There were three of them shouting and nagging trying to force an unwanted mask on my face, which I fought off with vigour I'm afraid; I hadn't even groaned and was so happy till then. One of them told me that she couldn't bear screaming; they didn't even pretend it was really for my benefit.'

(AIMS Quarterly Newsletter, Sept 1975)

'I had my last meal at 6.00pm on Sunday and at approx. 9.30am on Monday morning was taken to the theatre .... my baby was born at 12.45am Tuesday morning. I remained unconscious until about 2.00am. I asked to see my baby and phone my husband. I was refused with the words 'Shut up, you have caused enough trouble for one night. What do you think this place is?' I was shouted at for getting blood on a sheet and at no time could I find out if my baby was even alive.'

(AIMS Quarterly Newsletter, June 1974, p1)

'The relationship between the Albany Group Practice midwives and medical and nursing staff on the NICU requires particular attention. Case notes review and interviews indicated that the relationship is openly antagonistic'.

(CMACE Report, 2009)

[Note: the report does not specify who was antagonistic to whom, but in view of King's decision to withdraw the service, one can draw one's own conclusions]

The publication of the Winterton Report in 1991 resulted in 'choice' becoming flavour of the month. Since then we have developed an astonishing hypocrisy. While Trusts issue statements claiming that they respect women's choices the reality for many midwives is that if they truly act and support a woman who makes a choice outside the Trust protocols they can expect trouble and, what is worse, few of their colleagues will support them. Is it any wonder that we have a serious shortage of midwives?

Currently, the most recent publicised case of bullying involves the Albany Midwifery Practice. This practice, established over twelve years ago, was noted for supporting women and really respecting their choices. As a result, they developed an international reputation for 'gold standard' midwifery care, much to the chagrin of some members of King's College Hospital staff, it seems.

Despite midwives' success and favourable outcomes, King's carefully selected a specific group of cases of hypoxic-ischaemic encephalopathy (HIE) that occurred in a selectively short time frame (31 months), and commissioned the Centre for Maternal and Child Enquiries (CMACE) to investigate. Details of AIMS' critique of this flawed and unacceptable investigation can be viewed on our web site: www.aims.org.uk/Submissions/CMACECritique.htm

The Albany Practice has brought into sharp relief the tensions between medically dominated obstetric care and a midwifery focused practice that is truly 'with women' and designed to increase women's confidence in their ability to give birth, support their choices and truly enable the women to give informed consent.

Few midwives and doctors in the National Health Service have any understanding of informed consent; it is parroted at every opportunity, but few respect or understand its meaning. The failure to accept a woman's right to make decisions about her care are revealed in the flawed CMACE Report (see AIMS' critique www.aims.org.uk). In one section the anonymous authors of the CMACE report state: 'occasions will arise when definite, unequivocal and direct advice against home birth is essential' and 'women with risk factors for a poor outcome of labour should actively be encouraged to give birth in hospital, in keeping with local and national guidelines' yet, later in the report it is noted that 'The Practice also receives referrals from King's College Hospital midwives of 'challenging' women as it was felt that the individualised care offered by this service suited this client group.' The authors do not spell out what was 'challenging' but one can surmise that they were women who were labelled as 'high risk' and were not prepared to accept the standard obstetric advice.

The failure to respect the rights of the parents in our society is reaching an all time low. While more and more monitoring is encouraged there is less and less support and respect. Maria Newcastle in her article (page 7) reveals how the hospital staff refused to send a midwife to her home birth and continuously insisted that she should travel in labour into the hospital. It was only by chance that the community midwives arrived in time. No-one considers the risks of travelling across country in strong labour and ending up delivering at the road side; nor the effect on the woman's labour of unnecessary stress at this time. Perhaps if women who have had this experience send in a Serious Clinical Incident Report the establishment will begin to understand the risks involved and take effective action to provide an adequate service?

Many women choose a home birth because they are not prepared to repeat the bullying they endured in a previous labour, and some choose not to call a midwife at all. The reaction to this is often more bullying from midwives who consider they have the right to censure

the woman for that decision. Tabatha Pollock Ellam (page 22) relates the dreadful experience she had at the birth of her previous baby and their desperate struggle to arrange a home birth this time. As she says, 'I would rather give birth in a field over my local hospital.' Does anyone ever investigate why so many women adamantly refuse to go into hospital ever again? No, far better to continue the bullying by thinking up endless reasons for why they are labelled as 'high risk' and therefore 'must' be booked into a hospital.

Debbie Chippington Derrick looks at the contentious issue of vaginal examinations with specific reference to the NICE Intrapartum Care Guideline (page 8) and Mary Stewart considers the emotional effects for women of internal examinations (page 11). Vaginal examination was introduced decades ago without any research to indicate its value and continues to be used despite the disruption and discomfort caused to a woman in a normally progressing labour. No acknowledgement is made of the observations that skilled midwives use to determine what stage of labour a woman is at; and woe betide those midwives who fail to use a partogram at a home birth (another requirement designed for obstetrically managed deliveries that is as inappropriate in a home setting as it is in a hospital birth where the labour is progressing normally.)

In order for women to have a straightforward birth they need to know and have confidence in their midwife; they need to be in a place where they feel safe; and they need to have the kind of care where the midwife 'follows the woman', thereby enabling care to be provided either at home or in a hospital, depending on the woman's needs and intentions; and they need to be given accurate and evidence based information in order to make an informed choice. Where this kind of care is available the majority of women find their babies' births to be an empowering and positive experience. The Albany Midwifery Practice did all of this very successfully, as their statistics show (page 19); but the medically dominated obstetric services are deeply threatened by this, hence the current witch hunt and the reluctance to establish community based case load midwifery services in every area.

In the current climate of financial constraint ensuring that there is an Albany For All midwifery service in every area would save the NHS millions of pounds and thousands of women would be saved from unnecessarily traumatic deliveries, but are the politicians man enough to seriously implement the changes that need to be made? Or are we to see yet more tinkering at the edges and a repeat of the 'pretty wallpaper syndrome' that we witnessed in the 1980s when sterile obstetric units were last criticised and every unit had to have a 'home from home' room that paid lip service to good quality midwifery care?

Beverley A Lawrence Beech

A midwife from Blackburn with a caseload practice, said 'we wouldn't be here if it wasn't for Albany'

Reclaiming Birth Rally

The rally took place on the bright and sunny morning of the 7th March, and attracted almost 2,000 people. The Reclaiming Midwifery rally called for the Albany model of care, and other social models of midwifery care, including caseloading midwifery practices, free-standing Birth Centres and home births, to be rolled out across the UK, as well as for more midwives to be recruited in areas where there are shortages of midwives.

When King's College Hospital management decided unilaterally to terminate its nearly 12-year contract with the Albany Midwifery Practice in November 2009, there was a public outcry. The mothers and families affected by this decision were shocked and dismayed, as were childbirth organisations and midwives in Britain and across the globe.

The Albany Midwifery Practice has long been seen as an exemplar in midwifery care. It provided continuity of care in such a way that pregnant women would get to know and trust one or two midwives who would provide all their care. Even though the families looked after were among the most disadvantaged in the country the outcomes achieved by the midwives and women were truly remarkable. The women had more home births, more normal births and few caesarean sections and forceps births. They frequently used birth pools and few needed to use drugs for pain relief. The vast majority of women breastfed their babies at birth and most continued to at least the age recommended by the DoH. Fewer babies died, only 4.9 per 1000, much lower than King's or the average rate for the area (11.4 per 1000). Not surprisingly both midwives and families were very happy with the arrangement, and the Albany Midwifery Practice was fulfilling all the outcomes aimed for by the government.

Following the unprecedented decision by King's to close the Practice, an 'Albany Mums' group was immediately set up on Facebook and has attracted nearly 700 supporters. A petition calling for the reinstatement of the Albany Midwifery Practice was signed by over 4000 people from across the world. The Albany Action Group was set up with representatives from the Albany Mums, National Childbirth Trust (NCT), Association for Improvements in the Maternity Services (AIMS) and Association of Radical Midwives (ARM). This group initiated and organised a rally called Reclaiming Midwifery, in London, which was also supported by the Royal College of Midwives (RCM) and Independent Midwives UK (IMUK).

King's has attempted to discredit the care provided by the Albany Midwifery Practice by claiming it is unsafe. The Albany Mums and the Albany Action Group (see over) has spent months attempting to get King's to provide evidence to support these claims, but they have failed to do so and they have still failed to do so.

Nadine Edwards

Why does the Albany Midwifery Model work?

AIMS Vice Chair *Nadine Edwards* gives some background

The Albany Midwifery Practice was based in Peckham Pulse Healthy Living Centre in South London, England from 1997-2009, until King's College Hospital abruptly terminated its contract. It was one of nine community midwifery practices attached to King's in London, but was the only midwifery practice in England to have negotiated a sub-contract with a hospital Trust.

The seven self-employed and self-managed midwives in the Albany Practice provided midwifery care for over 200 women each year, referred from local GPs and from obstetricians at King's. The midwives looked after all the women during pregnancy, birth and postnatally whether or not they had any health complications and wherever they planned to have their babies. Most women were looked after throughout by a midwife they got to know and trust during their pregnancies.

The Practice worked in an area with high levels of deprivation. Southwark is 14th from the bottom of 354 districts in England, (with 1 representing the most deprived) in a Multiple Deprivation Index.[1]

The families looked after by this group of midwives enjoyed enormous health and well-being benefits, and together the midwives and women developed a positive birth culture that increased confidence, self esteem, knowledge and skills in both women and midwives.

'I think you grow because you grow to meet their expectations [...] They expected me to give birth well, they expected me to be a good parent afterwards and I grew to meet their expectations. You know? That's really powerful...'[2]

Not only was the service highly valued by women, but the safety outcomes were second to none. The perinatal mortality rate for Albany babies born between 1997 and 2007 was 4.9 per 1000. This compared with a perinatal mortality rate of 11.4 per 1000 in the Borough of Southwark as a whole, and a national perinatal mortality rate of 7.9 per 1000.[3] Its caesarean section rate was far lower than that of the local hospital and the national rate - 14.4%, compared with 24.1% at King's College Hospital in 2008. Breastfeeding rates were far higher than anywhere in the country consistently around 80% at 28 days. More women had vaginal births, intact perineums, used birthing pools, fewer had episiotomies, elective caesareans, inductions and fewer used pethidine and epidurals than at King's and in the other midwifery group practices. The women and babies enjoyed a high rate of normal birth and home births, because of the level of support and information they received from their midwives.

All in all the Albany Midwifery Practice most closely matched Government policy and targets, and contributed significantly to improving public health. This impacted positively on social cohesion and developed community strength and well-being, as can be seen by the vigorous, consistent and creative efforts of the 'Albany Mums' to oppose King's decision to terminate the contract with their Albany midwives (www.savethealbany.org.uk).

During pregnancy the midwives built a relationship with the women and their families. They helped women to feel confident about giving birth, and continued to support them if they or their babies needed medical interventions. They enabled women to make informed decisions to improve safety for them and their babies, as can be seen by their excellent outcomes.

During labour the midwives provided continuous support to the woman and her family, at home or in hospital, and after birth the midwives visited the woman and baby at home or in hospital regularly in the first few days to help establish breastfeeding. They stayed on call for each woman and family for up to 28 days.

All the pregnant women and new mothers were encouraged to come to the antenatal and postnatal groups facilitated by the midwives. During the groups, women were encouraged to share their experiences and learn from each other, and build supportive networks to help them as they became mothers. The Albany philosophy can be seen at www.albanymidwives.org.uk.

The Albany Practice was very much part of the local community, women continue to speak very highly of the service and of their midwives. The community is devastated by the withdrawal of the Albany Midwifery service and is doing all it can to call for its reinstatement. The Albany Action Group and the Albany Mums Group regularly contacts politicians, managers and Board members at King's, the press, the local Maternity Services Liaison Committee, the local Adult Services Scrutiny Committees, as well as raising funds for demonstrations, legal fees, a national rally and other events. The practice also enjoys support well beyond the Southwark boundary. Student midwives and experienced midwives continually applied to spend time with the Albany Practice to learn from the midwives. Many gave glowing reports:

'I have learned that the way the Albany midwives practice is the way forward for all midwifery practices, the benefits to all their clients is evident every time we met them. The trust and joy the clients show towards the midwives and vice versa can only benefit the service.'

'Continuity has a huge role to play in preserving normal birth and midwifery, not to mention home birth rates. Caseloading is possible and rewarding for both women and midwives.'[4]

Researchers frequently cite the practice as a model to emulate: it works for women and midwives, and the practice is renowned globally for its innovative approach to care during childbearing.[5]

I was fortunate enough to be invited on to the Advisory Board for the Normal Birth Project based at King's College London and led by Jane Sandall, Nicky Leap and Jane Grant. Because of this I was privileged to see many of the filmed interviews with the Albany midwives, and the mothers and fathers they cared for. It is evident from these that even the excellent evaluations,[6,7,8] cannot portray just what the Albany Practice Midwives were achieving. Their focus on safety, continuity, excellent information, support as and when it was needed, and the commitment with which this was done was truly remarkable. Listening to the women talking about their care was extremely moving - women who would otherwise not have had positive birth experiences or have had the opportunity to further develop their sense of agency and confidence as they became mothers.

I have also been fortunate enough to spend time with the Albany midwives and some of the women they have looked after. It is difficult to put into words the strong sense of community that they have developed: a sense of community we rarely now see. Despite all that has happened to these midwives, their loyalty and commitment to their community is unshakeable. There is not a sign of bitterness or resentment - they are still completely focused on the women, remembering individual women and families from many years ago, as well as all the women they have recently cared for. The women I have met are strong, courageous and resourceful women, and the sense of reciprocity from them is overwhelming.

This group of midwives was providing all that is being asked for by the Government par excellence: safety, choice, and social cohesion. Not only this - it had reduced interventions (and hence costs) to the point that a report by King's suggested that there is a lot to be learnt from the Albany Midwifery Practice to improve care at King's overall.[6] This was sustainable midwifery at its best and the termination of the contract by King's is short sighted, and a tragedy for the families it served, midwifery and the wider community.

Nadine Edwards

References

1. Office of National Statistics (2008) www.statistics.gov.uk
2. Leap N, Bastos M H, Grant J, Sandall J (2009) Normal Birth Matters: An Interactive, Multi-media Learning Package for Maternity Staff, Normal Labour and Birth 4th Conference, Grange over Sands, 10-12th June.
3. CEMACH 2008 www.cmace.org.u
4. www.albanymidwives.org.uk
5. Davies-Floyd R, Barclay L, Daviss BA, Tritten J (2009) Midwifery models that work. University of California
6. Demilew J (2007 King's Midwifery Services & Public Health Report - supporting wellbeing and tackling health inequality. King's College Hospital London SE5 9RS
7. Rosser J (2003) How do the Albany midwives do it? Evaluation of the Albany Midwifery Practice. MIDIRS Midwifery Digest 13 (2): 251-257
8. Sandall J, Davies J, Warwick C (2001) Evaluation of the Albany Midwifery Practice, Final Report. London: King's College

Some Facts ...

- British maternity services are running short of 4,000 midwives at present. The Royal College of Midwives states that 'England will still be suffering a severe lack of midwives by 2012 even if Government recruitment targets for an extra 3,400 midwives are met'.[1]
- Intervention rates are rising inexorably, Caesareans now stand at 24.3% nationally. This is costly as well as poor practice. Hospital Trusts are paid £2,579 for each Caesarean section compared with £1,174 for a normal midwifery-led birth. They are paid £3,626 for a Caesarean with complications. Taxpayers fund the excessive rates of Caesareans. The WHO states a Caesarean rate of over 15% is associated with more deaths and ill-health than health gains.
- The lack of midwives is leading to a significant number of women being left without the support they feel they require. In the Healthcare Commission's 2008 report, *Towards better births: a review of maternity services in England*, 25% of women stated they had been left alone during labour at a point when they felt anxious.[2]
- In badly over-stretched, under–resourced maternity services, there are increasing concerns about 'near misses', the numbers of poorer outcomes linked to extensive obstetric interventions, and less than optimum care. An independent inquiry in 2008 reported that an estimated 62,746 safety 'incidents' were recorded in English maternity units in a twelve-month period between June 2006 and May 2007, with moderate harm in 11% of cases (6,902); severe harm in 1.5% of cases (941) and death in 0.5% of cases (314 deaths).[3]
- The Albany Midwifery Practice in Peckham, south London, has been providing safe, woman-centred care for women from deeply disadvantaged backgrounds for twelve years. The Albany has been thoroughly evaluated twice, it has a far lower Caesarean section rate than King's College Hospital and a far lower perinatal mortality rate.
- The Albany gave genuine choice to the women and babies whom it served about place of birth and choice of midwife at birth. National maternity policy states that all women should have a choice by 2009. In October, 2009, the National Childbirth Trust released a study showing that less than 5% of pregnant women in the UK are free to choose where to have their baby.[4]

The Albany provided safe, woman-centred care for vulnerable women who want and depend on this care for themselves and their babies. Yet King's has forced the service to close down and limited its continuity of care. Why are women being denied safe birth in one of the few pockets of genuine woman-centred midwifery-led care in Britain?

Compiled by Jo Murphy-Lawless

References

1. RCM press release 16th April 2009
2. Healthcare Commission (2008) Towards better births: A review of maternity services in England. www.cqc.org.uk/_db/_documents/Towards_better_births_200807221338.pdf
3. O'Neill, Onora et al. (2008) Safe Birth, Everybody's Business: An independent inquiry into the safety of maternity services in England. London: King's Fund. www.kingsfund.org.uk/research/publications/safe_births.html
4. Dodwell, Miranda and Gibson, Rod (2009) An Investigation into Choice of Place of Birth. London: National Childbirth Trust www.nctpregnancyandbabycare.com/choice

Birth by yourselves...

Maria Newcastle tells her story

I had a baby girl, Matilda, at home a fortnight ago. It was a lovely birth; however, the labour was somewhat complicated by being told that we could choose either a hospital birth or birth at home by ourselves.

When my partner Neil phoned to ask for the on-call team to be contacted, he was told that they had just gone out to another home birth and that we 'had' to come into hospital. He was a complete trooper, and maintained that we had booked for a home birth, were not going to be coming into hospital and we were looking forward to seeing a midwife. Over the course of three or four phone calls, one with my sister, we were told:

- If we intended to stay at home, there would be no midwife in attendance
- If we chose to stay at home for the birth, we should call an ambulance if any problems arose
- That if a midwife was sent from delivery suite to provide care for me, I would be depriving other women of care.

It was extremely fortunate that the first lady gave birth very quickly and the team got to me in time. It was also helpful to the situation, though not to me, that the stress of listening to the phone conversations and mentally sorting out a staffing problem caused my contractions to wane from 40-45 seconds every two minutes to 25-30 seconds every five or six minutes. Eileen, the midwife who came out to me, agreed with me that it was the stress that caused my labour to ease off so much and was responsible for making it so long. This labour was just over six hours - my previous labours were four and three hours.

The staff at the hospital did nothing to try to arrange alternative midwifery cover, and if the first woman had not delivered so quickly, I'm not sure anyone would have come out to me. I was at the point of thinking that I would have to go in, when Eileen called to say she was on her way and would be with me as soon as she could. Despite my total belief that I can birth my babies perfectly well without assistance (and in the event I did - Matilda was born in water and no one touched her or me until she was a good 10 minutes old), I could not make a decision to decline any care whatsoever; the nurse in me needed someone to listen in to check the baby was coping, and I needed the two midwives, and two students, drinking tea in the corner for me to really let go and get into my labour!

Anyway, I intend to make a complaint to the Trust about being denied care at home, and my husband being encouraged to deliver the baby himself (I'm sure he'd be more than capable in an emergency, but this was not a time-critical situation) with paramedic back-up. I was able to stand my ground, and direct my husband and sister to do the same, in a way that I wouldn't have done had this been my first baby. I also feel that many women wouldn't have had the confidence or knowledge to be so firm in the face of what felt like blackmail and bullying, and while I'm glad I am capable of assertion even in labour, I am furious on the part of the many women who would not be.

Maria Newcastle

AIMS Comment:

This situation, and variants of it, is a tactic frequently used to coerce women into hospital. If a woman calls a midwife, there is a duty to attend, but women frequently do not know they can refuse to transfer. This adds unnecessary stress to pregnancy and labour, and is not good for mother or baby.

Serious Clinical Incident

A Serious Clinical Incident (SCI) is defined as 'any unintended or unexpected incident which could have harmed or did lead to harm for one or more patients being cared for by the NHS.' Forcing a woman in advanced labour to travel across country when she had booked a home birth, and expected a midwife to attend, is a Serious Clinical Incident and it should be reported. The Trusts, however, do not see it this way. It is, therefore, important that you make a report yourself.

The National Patient Safety Agency (NPSA) collects and analyses information on patient safety incidents in the NHS. It then makes recommendations to reduce the risk of patient safety incidents. The NPSA can be contacted via its website:

www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/

Alternatively you can write to NPSA directly or telephone the Helpline on 0845 601 3012 and state that you are a patient who wishes to report a Serious Clinical Incident.

Tip: if you take a camera or video camera to hospital and you have issues with your care, photograph or film your notes in case you wish to complain. AIMS is hearing from women who are having difficulty getting copies of notes. If you video conversations, you may find that attitudes towards your care or tricky situations change.

VEs - Essential Diagnostic Tool?

Debbie Chippington Derrick looks at the contentious issue of vaginal examinations with specific reference to the NICE Intrapartum Care Guideline

Vaginal examinations are extremely unpopular among pregnant and labouring women but seem to be considered a normal part of routine care by most health professionals; what does the NICE Intrapartum Care (IPC) Guideline actually recommend about their use?

The Guideline is confusing and contradictory, stating repeatedly that vaginal examinations are intrusive and should be avoided unless necessary, then elsewhere making recommendations based on information gained from carrying out vaginal examinations. The Guideline fails to consider any possible alternative methods of assessing whether or not labour is progressing normally.

In the summary of the Guideline it reminds health professionals to consider whether the examination is necessary, and to remember how difficult women may find the procedure, saying:

Healthcare professionals who conduct vaginal examinations should:

- *be sure that the vaginal examination is really necessary and will add important information to the decision-making process*
- *be aware that for many women who may already be in pain, highly anxious and in an unfamiliar environment, vaginal examinations can be very distressing*
- *ensure the woman's consent, privacy, dignity and comfort*
- *explain the reason for the examination and what will be involved, and*
- *explain the findings and their impact sensitively to the woman.*

(NICE IPC Guideline page 17, summary)

The summary above encapsulates the problem: that they are difficult for women and should only be done if absolutely necessary, but that they are deemed necessary as they are the only easily documented measurement of progress in a system where more descriptive assessment of labour is not accepted.

Nowhere in the Guideline are there clear indications about when vaginal examinations might be considered essential, when they might be considered a low priority option, or how monitoring of labour should be carried out when women do not consent to these examinations.

> ***'The first thing they wanted to do was an internal, and they were quite insistent about that ... and that was horrible, it was quite horrible ... I was in quite strong labour by then, and it was just interfering, there didn't seem to be any need for it'***
>
> ***Edwards 2001***

Being *'aware that for many women … vaginal examinations can be very distressing'* is all very well, but the day-to-day reality on labour wards is that if a health professional has already made up his or her mind that a vaginal examination is necessary then consent will be assumed and a vaginal examination carried out. Women may have said yes to the examination and this is accepted as consent, despite the fact that they may have actually felt they had no option but to agree.

> ***One woman commented that she was unaware that her primary midwife would want to do a vaginal examination in order to decide when to call the second midwife. She reluctantly agreed, 'I just thought, oh, right, that's what we have to do. Whereas afterwards you think, well, did we need to do that?' I did find it a horrible part of it - and painful, and not really part of the process of getting [baby] out necessarily. I don't think I really trusted the midwife after that'***
>
> ***Edwards 2005***

The prevailing attitude seems to be that women should expect to leave their dignity at the door and put up with the management of labour and all it entails, for some unproven assumption of safety for their baby.

In chapter 7 ***Normal labour: first stage***, the first recommendation is that *'Clinical interventions should not be offered or advised where labour is progressing normally and the woman and baby are well.'* The problem with this statement is that unless a vaginal examination is carried out, most health professionals will be unable to assess whether labour is progressing normally. Nowhere in the Guideline are alternative methods for such assessment discussed.

Vaginal examinations are considered in sections 7.4 ***Observations on presentation in suspected labour*** and 7.6 ***Observations during the established first stage of labour***. This separation itself is interesting as these two different states are often categorised by cervical dilation of greater or less than 4cm. The Guideline seems to omit the issue of how this categorisation should be made and why. Most health practitioners would assume a vaginal examination should be done to establish this.

In 7.4 there is an excellent introduction which highlights many issues of concern to women, but still fails to allow for the possibility that vaginal examination will not be done:

The intimate nature of any vaginal examination should never be forgotten and, as with any procedure, consent obtained. While they may be useful in assessing progress in labour, to many women who may already be in pain, frightened and in an unfamiliar environment, they can be

very distressing. The adverse effect on the woman may be reduced by having due regard for the woman's privacy, dignity and comfort. Good communication, as in all aspects of care, is vital and caregivers should explain the reason for the examination and what will be involved. Caregivers should also be sure that the vaginal examination is really necessary and will add important information to the decision-making process. The findings, and their impact, should also be explained sensitively to the woman - using the word 'only' when referring to the amount of dilation may not be a good start and could easily dishearten or even frighten her.

(NICE IPC Guideline page 142, section 7.4.6)

A woman called back after her first baby was born to tell her story. She had been anxious about birth and had worked hard to prepare herself and increase her confidence and finally approached birth feeling much more confident.

She went into hospital in strong labour and a lovely, young midwife supported her, did a VE and said she was 7cms dilated. The midwife told her how well she was doing and everyone was delighted. She then told the woman that because she was newly qualified she would need to get a senior midwife to check the VE.

The senior midwife checked and said that she was only 4cms if that. The woman said she 'crumbled' and started to cry. She was then offered pethidine which she took because she felt so deflated, and shortly after the baby was born. She described the labour as traumatic.

a call to AIMS

This is followed in the introduction in 7.6.6 by the statement *'A vaginal examination during labour often raises anxiety and interrupts the woman's focus in labour.'*

'if she'd examined me, I could really picture myself just getting closed up, thinking of someone touching me inside'

Edwards 2001

Then in the review of the evidence in 7.6.6 the lack of evidence of the benefit of vaginal examinations is acknowledged. NICE was only able to find one study to provide this evidence and concludes:

'There is low-quality evidence on the frequency of vaginal examinations during labour, with some evidence that the number of digital vaginal examinations is associated with neonatal and maternal sepsis, where the membranes rupture prior to the onset of labour.'

However, despite this apparent conservative approach to the use of vaginal examinations, the Guideline remains confusing: sections on monitoring progress of labour and delay in the progress of labour are based mainly upon changes in cervical dilation, information that will not be available without vaginal examinations having been carried out.

It would be interesting to know how many women are really making informed decisions about having vaginal examinations and giving proper consent for them. How many women are informed about how little is known about the risks and benefits of vaginal examination? From our knowledge of women's experiences, we know that many women are actually coerced into giving uninformed consent, by staff leading them to believe that vaginal examinations are necessary for the safety of themselves or their baby and that therefore to refuse would be unthinkable. Even when women are well informed and have decided against vaginal examination, they often find their decision is not respected.

'it was straight away into a VE. Like I just want to give you a VE, okay? I felt, oh God, this is happening straight away. I felt, the power's being taken and they were going to start taking control. But I was really relieved when [main midwife] said, no, we've already discussed it and she's not going to have one. That kind of came at the very beginning when they arrived and it really mattered then to know that I could trust her with something like that. I felt I could trust her further, because she was taking my side above her colleague's really.'

Edwards 2005

At the beginning of section 7.4 ***Observations on presentation in suspected labour*** there is acknowledgement that many practices in monitoring labour are carried out because it is *'traditional'* to do so:

'It is traditional to carry out a number of routine observations of the woman and the baby. These are aimed at assessing maternal and fetal health, determining the stage and progress of labour, evaluating the woman's needs, determining whether admission to her chosen place of birth is required, and, if not, what follow-up observation and advice is required.'

(NICE IPC Guideline page 141, section 7.4)

Such tradition will affect the way that interventions are viewed and offered, and how well accepted it may be for a woman to decline the offer of a vaginal examination or for a midwife really not to carry them out when in her professional experience they were unnecessary, especially if she felt her professional opinion was at conflict with the practices of others.

This confusion about the routine and conservative use of vaginal examination is highlighted in the ***Recommendations on initial observations*** (page 144), saying *'If the woman appears to be in established labour, a vaginal examination should be offered'*, but then going on to say in the following paragraph that healthcare professionals should *'be sure that the vaginal examination is really necessary and will add important information to the decision-making process.'*

This confusion is carried through to the IPC quick reference guide, with the first box warning *'Ensure exam is really necessary,'* then the following box, which is on initial assessment, saying *'Offer vaginal exam'* which

apparently covers all women and not just those who appear to be in established labour.

In the Guideline all discussion of the progress of labour is in terms of cervical dilation. Chapter 14, which covers delay in the first stage of labour, says in the introduction:

'Delay in the first stage of labour has been defined in a number of ways and there is no universal consensus. It has been traditional to define delay largely by the rate of cervical progress without taking into account either maternal uterine activity or descent or rotation of the fetal head during labour. Although it is acknowledged that the duration of labour is dependent on parity, clinical practice and local labour guidelines rarely make that distinction.'

Again this makes it clear that monitoring cervical dilation is such a *'tradition'* that there is no consideration of how any delay in labour would be diagnosed without that information, despite the clear and repeated cautions against the use of vaginal examinations.

Suspected delay is given as less than 2cm dilation in four hours, but no other measures are suggested.

> ***'I was assured that they would only do them [vaginal examinations] out of necessity, but I still don't understand why they're necessary. Somehow I have the feeling that they can't observe women and feel that things are alright without having to use physical monitors all the time. That is what I find slows me down, interferes with me.'***
>
> ***Edwards 2005***

There are recommendations on the use of partograms to monitor the progress of labour and these are carried over from the NICE Caesarean Guideline. It is NICE policy to carry relevant recommendations over from other guidelines to avoid conflict between guidelines. The recommendation says *'A partogram with a 4-hour action line should be used to monitor the progress of labour of women in spontaneous labour with an uncomplicated singleton pregnancy at term, because it reduces the likelihood of CS.'* This recommendation is based solely on the rate of caesarean section and not on any other outcomes for mother and baby.

There is a failure to acknowledge that completing a partogram requires a vaginal examination to be carried out and the potential adverse effects of this, nor is consideration given to the issue of obtaining consent. A further concern is that the research this is based upon made comparisons only between partograms with different action lines and does not compare the use and non-use of partograms. There is acknowledgement of this aspect in the IPC Guideline in the research recommendation which says:

'Studies looking at the efficacy of the use of the partogram, and the comparison of a partogram with an action line and one without, should be carried out.'

It is unclear why this recommendation did not extend to appealing for research that considered whether the use of partograms is of benefit to women and babies at all.

This raises another concern: the research on partograms did not provide information on outcomes other than the caesarean section rates and in the evidence review of the Caesarean Guideline there is acknowledgement that *'No study has evaluated tests based on maternal and fetal outcomes,'* so this recommendation is being made without knowing the effects, positive or negative, that partograms may have on mothers or babies.

The IPC Guideline does acknowledge well the potential negative effects of vaginal examinations, and does urge caution in their use. However, so much else in the Guideline requires information about cervical dilation that it can do nothing but leave those caring for women in a quandary about which advice they should be following.

This Guideline fails to draw on midwifery skills that allow labours to be monitored without this intrusive procedure or recognise that such knowledge even exists.

Debbie Chippington Derrick

Further reading on VEs

Bergstrom, L., Roberts, J., Skillman, L., and Seidel, J. (1992) 'You'll feel me touching you sweetie: Vaginal examinations during the second stage of labor', Birth, 19(1), 10-18.

Warren, Chris (1999a) 'Invaders of privacy', Midwifery Matters, 81, 8-9.

Warren, Chris (1999b) 'Why should I do vaginal examinations?', The Practising Midwife, 2(6), 12-13.

References

NICE Guideline. Intrapartum care: care of healthy women and their babies during childbirth, September 2007 www.nice.org.uk/CG55

Edwards, Nadine Pilley (2005) Birthing Autonomy: Women's Experiences of Planning Home Births, Routledge, London, New York.

Edwards, Nadine Pilley (2001) 'Women's Experiences of Planning Home Births in Scotland: Birthing Autonomy', Unpublished PhD Thesis, University of Sheffield, UK.

The All-Wales clinical pathway for normal labour (published just before the NICE IPC Guideline in 2003) differs, in that it relies heavily on the use of VEs for assessing the progress of labour:

Under **Expected progress in labour - first stage of labour:**

A vaginal examination within four hours of receiving 1:1 midwifery care.

Re-examine vaginally four hours later in the absence of signs of full dilation and if there is progress of at least 2cm then re-examine four hours later, if not, but there is at least 1cm then two hours later in the absence of signs of full dilation. If less than one then exit the pathway.

Full dilation is defined by VE or by a visible vertex at the perineum.

Vaginal examination in labour - what do women say?

Midwife *Mary Stewart* considers the emotional effects of internal examination

The subject of vaginal examination is contentious, as Debbie Chippington Derrick has rightly pointed out in her article on page 8 and, despite the NICE guidelines, there is scant evidence as to how, when or why they should be performed.

My aim in this short article is to explore what some women say about vaginal examination and to consider what this means for health professionals and for women as users of the maternity services. The quotes I use in the article are all taken from research that I undertook for a PhD.[1] In my research, I interviewed ten women, six who were pregnant for the first time and four who were pregnant with their second child. All women were interviewed twice: once towards the end of their pregnancy, and a second time approximately two weeks after the birth of their baby. Interviews took place in the woman's home and were tape-recorded with her written consent. All names have been changed to protect participants' confidentiality.

Pregnancy - an absence of information

The most striking feature of the interviews with women in pregnancy is the absence of information that they had been given. All the participants in my research had attended some kind of antenatal preparation: some had been to sessions run by the NHS, some to NCT classes and some to both. I asked women who were pregnant for the first time if they could remember vaginal examination being discussed during these classes, but none of them could recall this. As one woman remarked:

'It's funny, because I've been to all the classes and no-one's mentioned anything about internals at all ... there's been nothing said about them at all. So how often do you think I'll have them done?'

Anna, 37 weeks pregnant, first baby

Another participant also worked as a midwife. She recalled:

'I don't remember it being in the antenatal classes really, not ... not specifically. In saying that, I think they said that ... when they're talking about progress in labour they said, "Oh, you'll be examined and it'll be like 4cms or whatever and you've got to get to 10cms," but they didn't say what happens throughout a VE, d'you know what I mean? Does that make sense?'

Geraldine, 36 weeks pregnant, first baby/also a midwife

It seems that, despite the fact that they tried to prepare for labour and birth, it was hard for women to get clear information about this common procedure and what it actually entails. In fact, all the women in my study did know something about vaginal examination, but they indicated that they had got this information from friends and/or books they had read, rather than from midwives or NCT teachers. Not surprisingly, the information that women had was therefore somewhat limited. One woman was under the impression that the examination was only done as a 'one off' to confirm that labour had started but, during the interview, she picked up on the fact that I referred to vaginal examinations in the plural. Our conversation went as follows:

Hope: 'D'you mean I'll have more than one?'

Mary: 'Well, yes, they're usually done four hourly, though it often varies so, yeah, you might have several ... but you don't have to have them done at all, they can't do them without your consent and you can say "No."'

Hope (in tones of amazement): 'You mean I have a choice?'

It is deeply worrying that a woman can reach the late stages of pregnancy without realising that she can choose to decline any or all medical interventions, from something quite benign, such as measuring blood pressure, to something as intimate as vaginal examination.

After the birth - mixed feelings

In the interviews after the birth of their baby, many participants commented that vaginal examination was painful or uncomfortable. One woman recalled the experience with great clarity:

'The second one I had, yeah, actually, I found that quite horrific ... I decided, it was me that said "I would like to have my waters broken for me" thinking it was going to make things quicker, so it was my decision to have it done but I'd read about having it done and that it was painless and that it was fine and that it was just like a crochet hook, so I'm thinking "Oh, this is going to be fine" but I found it really horrible ... I knew it was going to involve having a thing stuck up inside me but it seemed to take ages and it felt just awful, I felt horrible, I hated the feeling, it was a physical thing "eugh, this is really horrible" but, you know, it was my decision to have it done and at the end of the day I'm sure it was the right thing to do.'

Barbara, 2nd baby, 12 days postnatal

It is interesting to note the responsibility that Barbara takes for this experience and the way that she tries to justify it to herself as 'the right thing to do'. However, for some women the discomfort was mitigated by what they perceived as practical necessity. For example, one woman who also had a 2-year old daughter said:

'She [the midwife] just examined me on the floor but it

was really, really painful, it just hurt and I was going "Ow, ow, stop" ... She tried her best and I know it was necessary to do it, because I did want to know about sorting Susy [her older child] out and going in to hospital but it did really hurt, but then it was fine once she'd done it and I was glad I knew what was happening'

Kate, 2nd baby, 2 weeks postnatal

Perhaps surprisingly, some women felt that vaginal examination was positively advantageous. One woman remarked:

'[The midwife] told me I was 7cms [dilated] and that was great, that came at just the right time, because I was beginning to wobble and think I needed more painkillers, but then I thought "no, I can do this"'

Jill, first baby, 15 days post-birth

may be traumatic for all women, whatever their history

However, another struck a more wistful note:

'It would be nice if they could tell without having to do an internal, wouldn't it? You know, if they could say "oh, you're this far, or this far, or this far" ... some sort of update along the way so that, you know, you don't have to have VEs at all ... [voice trails off]

Kate, second baby, 11 days post-birth

What can we learn?

The evidence from women in this study indicates that health professionals have a lot to learn. Most importantly, the subject of vaginal examination needs to be discussed in pregnancy, so that women know what it entails, why it might be offered, what information it can provide (and just as importantly, its limitations), and their absolute right to decline the procedure. We know that most women do not attend pregnancy preparation classes so, although vaginal examination can and should be discussed in these group situations, it should also be raised with all women on a one-to-one basis during pregnancy. Alongside those discussions, there needs to be an acknowledgement that vaginal examination may be uncomfortable or painful. Several women in this study said that midwives prepared them for the procedure saying it was similar to a cervical smear, but women felt this was very misleading and unhelpful.

It has been suggested that some women find vaginal examination traumatic because they have previously experienced sexual abuse. However, I think we should also recognise that the procedure may be traumatic for all women, whatever their history. Vaginal examination can be an enormously useful and important examination. It can provide information about cervical dilation and, just as importantly, the position of the baby, that may have a direct impact on progress in labour and that is difficult to access in any other way. However, just as with any other procedure, it has its limitations. It is one of a range of tools that midwives and doctors can use to assess labour and, on its own, it is severely limited. It should be used in conjunction with a whole range of tools that can also be used to assess labour, such as observing a woman's behaviour and the noises she makes. Most of all, it must only ever be done once the woman has given her clear consent and, just as importantly, the midwife or doctor doing the procedure must stop immediately if the woman asks or if she becomes distressed. Anything less can surely be regarded as assault.

Mary Stewart

Reference

Stewart, M. (2008) Midwives' discourses on vaginal examination in labour, University of the West of England: unpublished PhD dissertation

Team Work?

The issue of team work arises again and again - for example the King's Fund (report in AIMS Journal Vol 20 No 3) recommended improving communication in order to improve outcomes.

AIMS thinks this would work best if 'team' changed its meaning somewhat - to putting the woman at the head of her team, supported by a midwife with whom she had the opportunity to develop an ongoing trusting relationship. That would enable the rest of the team members to provide support if and when the need arose and would go some way to empowering the woman to make the decision whether or not to access it. A trusting relationship with the midwife who could help the woman engage with other services if needed might help address the communication issues that are so often criticised.

16 years of improvements?

Pat O'Brien takes a critical look at the portrayal of birth

I noted with interest the Channel 4 programme advertised 'One Born Every Minute' [first shown on February 9th 2010].

Knowing myself, I thought I should probably NOT watch it for fear of getting wound up about all the issues I care so much about surrounding childbirth. However, against my better judgement, I decided to watch the programme in its entirety in the hope that I would be pleasantly surprised by the advances made in midwifery over recent years. After all, it is now 16 years since I had my first baby. Things had bound to be a lot better … hadn't they?

I had been right in the first place … I definitely should not have watched this programme as now I am not only thoroughly depressed, but also seething with anger.

I witnessed:

- A woman lying on her back to give birth, when she had already said she was most comfortable on all fours.
- The same woman being threatened that they would have to call the doctor if she didn't push the baby out quickly.
- A delivery room fraught and full of fear.
- A woman made to change position to allow for fetal monitoring.
- A midwife saying the baby's heart rate was dipping during contractions (as it does normally) but engendering fear in the mother that this was abnormal and telling her 'the baby has had enough now' as if to frighten the mother into pushing harder.
- The same woman being told she needed to sit further forwards in order to push, adopting a position which closes down the birth canal and makes pushing LESS effective.
- No one encouraging the mother to stand or get on all fours to harness the forces of gravity.
- No constant companion by her side to help her through the pain and provide reassurance that all was perfectly fine.
- A woman bullied by all those in the room including her husband and being instructed to push on request, and even to hold a sustained push for as long as possible (which is not good advice).
- A woman who, having been told her baby would be 'pulled out of her by the doctors' if she didn't push hard enough, was then told not to panic.
- A woman apologising throughout her labour for inconveniencing the midwife!
- And, I suspect, a woman who will leave the hospital grateful for the fact she has a healthy baby and unquestioning of all the compromises she was forced to make to the 'normal birthing process' and the risks she and her baby ran BECAUSE of those compromises.

HAS NOTHING CHANGED IN 16 YEARS?

Pat O'Brien

'One Born Every Minute' is filmed at The Princess Anne Hospital in Southampton, described as 'a specialist unit looking after women and newborn babies'. Almost 6,000 babies are born each year under the hospital's care, and over 300 staff coordinate the care as women choose to give birth at home, at the hospital or at the nearby stand alone birth centre.

Channel 4 says that 'One Born Every Minute' aims to observe the dramatic, emotional and often funny moments that go hand in hand with bringing a new life into the world, from the perspective of the soon-to-be parents and family, as well as the hospital staff.

'One Born Every Minute' celebrates what it really feels like to become a parent, by taking a bustling maternity hospital and filling it with forty cameras. Did that make a difference to care? If you have a comment, please do let us know.

Out of My Depth?

Independent Midwife *Virginia Howes* looks at the portrayal of birth and midwifery in the media

I got up at 7am on 14th December having spent a very restless night unable to get the Amanda Holden television programme, 'Out of My Depth', that was shown on ITV the previous night, out of my head.

I spent the rest of the day speaking to colleagues and women to see if they were as appalled as I was. There were many opinions: some pleased that the public would know how difficult it can be working as a midwife, most thought Amanda did very well and tried her best as any student midwife does, but most thought it was as awful and upsetting as I did. The worst response has been from pregnant women ... that response - utter terror.

I have also visited many parenting websites where expectant mums discuss their coming babes on line for all to see and I want to weep due to the fear they have been left with by the programme. Luckily other mums appeared to be reassuring them! However, that should not have to fall on other mums. Messages about childbirth originate with professionals, and we need to stand up and be counted, for the message from that programme was wrong.

Whilst I accept the hospital and staff concerned may have had no control over editing, I am absolutely appalled and ashamed that they did not anticipate the potential outcome and only allow positive filming. Instead, once again, childbirth on TV is shown as a dangerous event that women need saving from. I understood that the role of a Consultant Midwife was to promote normal birth, not to perpetuate the medical model. If Amanda Holden was there to learn the role of the midwife, she should have been learning normal pregnancy and childbirth, for a midwife is the specialist in normal birth. Once a woman requested an epidural, the filming should have stopped. Use of epidurals, drips, instruments and monitors is not normal birth and rarely is it midwifery.

Having myself taken part in TV birth programmes, such as Home Birth Diaries, I have no issue with them as such. They can be a wonderful source of education for women, the public and midwives. However, according to my Midwives Rules I have a duty of care to women, and according to me that duty includes how I portray and promote childbirth to the women I serve.

In every current respected midwifery publication available, authors such as Wagner, Odent, Downe, Walsh, Kitzinger, Kirkham, Balaskas, Page, Wickham and many more highlight the dangers of disempowerment and the cascade of intervention. Student midwives learn about it on a daily basis and are encouraged to keep birth normal. The medical model of childbirth demonstrates how a woman is put into a hospital gown, laid on a bed, becomes distressed, asks for an epidural, then, due to the epidural, the baby has a drop in blood pressure and shows signs of distress, is torn from her body with instruments, is in a short-term bad condition due to the above but, hey presto, the midwife or doctor saves the baby and the woman is grateful. It truly is shameful to show that kind of approach when so much work is being done to make changes and to keep women and babies safer by steering them away from medicalised childbirth. However, if that is usual in most labour wards then it will become normal and I strongly feel those midwives who accept or promote it will become obstetric nurses.

Less than half of childbearing women in this country have normal childbirth, mostly due to being cared for within a medical model. The definition of 'normal' (to arrive at this terrible figure) is very loose! If we considered physiological birth, which is, as studies show, the safest way to have a baby, the figure is reduced by half again. How can that be when women are so good at giving birth? How did we survive for so many millions of years if childbirth is so damaging? We professionals have a lot to answer for because the messages we give are the ones that women take on and last night gave a very poor view of childbirth. My husband, who hears about childbirth on a daily basis, thought that poor floppy baby was dead. What must an expectant mother have thought?

In this country childbirth is a very safe process which sees 7 in every 1000 babies die. The programme was around an hour long. The ratio of time spent on talking about death and dying was disproportionate and completely inappropriate with no other reason than TV sensationalism. Why didn't Amanda meet the midwife who has her lead role in breastfeeding or the smoking cessation midwife? Why was it the bereavement midwife?

With such a high-profile TV personality, a golden opportunity was available to show normality, birth and midwifery in a positive and empowering way. Both births attended by Amanda showed women on their backs, on beds, in hospital gowns; one baby received unnecessary, therefore potentially damaging, nasal suction. I know of no recommendations or good practice guidelines that suggest suction for a pink and breathing baby.

Why was Amanda not invited to a home birth, a water birth, a squatting birth, a woman on all fours even? Why not a NORMAL birth? If a woman who'd had a baby before had been chosen, the chances of normality would have been higher and continuity could have been the same ... Amanda would have had just as many touching tears, the TV would have been just as compelling but the message to childbearing women would have been very different ... it would have been empowering.

I am ashamed of the profession I love, ashamed if they think it is OK to tell women that childbirth is a dangerous terrifying event that they and their babies have to be saved from, because it's not and the rest of my career will be spent giving THAT message.

A public inquest in Ireland

Following his birth at home, a baby died in hospital; report by *Jo Murphy-Lawless*

On 5th November 2009, an inquest was held in Cork City Coroner's Court about the circumstances of a baby who died in hospital some hours after he was born at home in West Cork on 3rd January 2009.

I want to report on the inquest proceedings, but first I will describe some of the surrounding issues about home birth in the Republic of Ireland. Home birth remains an outlier amidst an intensively centralised, consultant-led (and highly profitable) system of maternity care. Midwives struggle within that system to provide any semblance of woman-centred care. Many midwives give up: they give up practice or they give up trying to work against the grain of rigid institutions, and the notion of a woman and midwife working in partnership to provide a safe and secure environment for birthing becomes a distant dream. Nonetheless, a core group of dedicated research and practice midwives have worked extremely hard to develop spaces within this system, with the two pilot midwifery units in Drogheda and Cavan contributing significantly to the impetus for women and midwives to recover the contexts of birthing.

Working quietly alongside that major undertaking and other small developments has been a group of independent community midwives (ICMs) whose number has varied from 14 to 21 over the last two decades who have cared for women birthing at home. There are currently 15 independent community midwives actively practising in Ireland. A number of the midwives work in the Cork/Kerry region, an expanse where the countryside is magnificent but where the population remains sparse and the roads poor. For women in this region, the drive to Cork University Maternity Hospital to give birth is fraught. The incidents of babies born before arrival at hospital and the resulting anxiety for women about this possible outcome[1] were some of the factors, the major one being many women's expressed desire for the values of home birth, that prompted the local health board some years ago to set up a scheme where independent midwives were paid by the health authority to provide a home birth service.

While the midwives were not direct employees of the health board, women could apply to the health board to have their home birth fees covered and the midwives could register with a coordinator for the service within the public health division of the health board. This coordinator also provided some organisational infrastructure for the midwives who instituted regular meetings to explore practice matters. Several years ago, when the insurers for the Irish Nurses Organisation withdrew cover for independent midwives, a Memorandum of Understanding (MOU) was eventually drawn up by the overall national authority, the Health Services Executive, to provide insurance for the ICMs as long as they guaranteed their adherence to the strict inclusion and exclusion criteria of the MOU.

The inquest, which was attended by a considerable number of reporters from the national press, lasted for some hours. In seeking to establish the reasons for the death of a beautiful little baby boy, a first baby for his 23-year-old mother, the Coroner heard the statements and testimony of seven people: the Garda Siochana (police) called to establish that an untoward death had taken place, the attending midwife, Bridget Sheeran, a general hospital doctor who lived at the other end of the converted farm dwelling where the mother gave birth and who was called to assist Bridget soon after the mother had given birth, the HSE coordinator of the Domiciliary Midwifery Service, the consultant obstetrician whom the mother had last seen in the third trimester of pregnancy, the consultant paediatrician who dealt with the baby after he and his mother were transferred to hospital post-birth, and the Assistant State Pathologist who reported fully on the post-mortem she performed. The parents of the baby boy were away. However, the grandparents, who were there throughout their daughter's labour and birth, attended the inquest.

It was a very intense session. Bridget meticulously described the events from when she arrived at the young mother's side at 10.22 pm the previous night, over the next ten-and-a-half hours to the point of transfer to hospital. As her notes and deposition convey, the labour appeared normal in every respect, the fetal heartbeat strong, the mother making excellent progress, dealing very well with pain using a birthing pool and homeopathic remedies. The mother had requested a care plan with minimal intervention in labour. In keeping with the guidelines for the home birth scheme, Bridget informed the ambulance service of the precise location of the house should they be needed. The mother left the pool and laboured in an upstairs room for the final interval. With her consent, she had one VE about 20 minutes before the baby was born. With birth imminent, some light, thin and minimal meconium appeared on the spontaneous rupture of membranes. The baby was born at around 8.17 am, cried and opened his eyes. His airways were clear and Bridget placed him at once in the mother's arms, cord uncut, as she wished. He had an Apgar score of 5. Within a minute, Bridget faced two obstetric emergencies. The baby went 'flat' and she needed to begin immediate resuscitation administering oxygen, and later doing chest compressions, while the mother was haemorrhaging. The baby began to bleed frank red blood from his nose. Bridget administered syntometrine to the mother and the placenta fully delivered but in what is known as a 'dirty Duncan' delivery which means that it delivered with its rough side, the maternal side, where it had been attached to the womb, detaching and delivering sideways, whereas usually

the fetal shiny side presents first in a nice rounded shape for ease of delivery. The ambulance had been called and when the team arrived some 20 minutes after the baby was born, mother and baby were transferred to Cork University Maternity Hospital. The baby died some six hours later in hospital.

The mother had met all the inclusion criteria of the domiciliary scheme; all her antenatal care, including attendance with her GP and hospital with a scan and appointments with the obstetrician, indicated a healthy normal pregnancy. There was nothing untoward in the labour except the thin light meconium when the mother was actively pushing, about which meconium there would be considerable ambiguity as to its relevance. The Assistant State Pathologist who conducted the post-mortem and who had sent samples to experts on placental malfunction, in addition to her own analysis, concluded that a retro-placental clot had resulted in hypoxic ischaemic encephalopathy (HIE), leading to multiple organ failure and the death of the baby. She concluded that place of birth would have made no difference to the outcome and said 'these things happen'.

being in hospital would not have prevented the baby's death

The jury found that death was from natural causes and there was no recommendation or rider made about the circumstances. Throughout the morning the Coroner, who was scrupulous in establishing context and detail, referred warmly to the baby by name, Baby Tadgh, and extended the sympathies of the court on this tragedy to the absent parents and the grandparents, as did the head juryman and the Garda Siochana. As distressing as it was to hear all that had transpired, the court was deeply respectful to Baby Tadgh and to his family.

The same cannot be said of Matthew Hewitt, the consultant obstetrician who had seen the mother during the pregnancy. Under oath, he argued amongst other points that although there had been nothing abnormal at the time of her last consultation, there had been mention in the testimony of both Bridget and the coordinator of the domiciliary scheme about high-risk and low-risk pregnancies, that this was a false dichotomy, and that labour was only ever normal in retrospect. Mr Hewitt stated that while home birth was more comfortable for the mother, it put her baby at greater risk and that he had warned the mother of this. Home birth was controversial and in his judgement no woman should give birth at home who lived further away than 20 minutes' transport to hospital. Bridget had stated that the mother's emotional state during labour, working hard and focused, in conjunction with vital clinical details, contributed to her assessment that all was progressing well. Mr Hewitt rejected this, saying the woman's emotional state had no bearing whatsoever on her progress in labour. When he attempted to question other aspects of the mother's care, the Coroner warned him that he would not be permitted to exceed the terms of reference of the Coroners Act, not in her courtroom. Despite that rebuke, when following the evidence given by the Assistant State Pathologist, the Coroner asked Bridget to reconfirm details about the way the placenta delivered, and Bridget described the 'dirty Duncan', Mr Hewitt burst out angrily from the floor of the chamber that he had never before heard of such a thing. We may note that consultant obstetricians are usually not there when placentas are delivered and little concerned with what may be regarded as the 'dirty work' of birth. In his testimony, the paediatrician argued that only in hospital are there sufficient personnel with necessary skills and equipment for successful resuscitation. Yet resuscitation was not the issue according to the Assistant State Pathologist. The HIE and multiple organ failure were an inevitable and inescapable consequence of the retro-placental clot.

The heavy press presence must have been very difficult for the grandparents, and yet the young woman's father told reporters afterwards that though they were all devastated at the loss of Baby Tadgh, his daughter had the right to give birth where she chose, at home, and that being in hospital would not have prevented the baby's death.

I attended the inquest proceedings to observe an important public event focusing on birth, but most of all to be a presence for an excellent midwife who had done her best in deeply traumatic circumstances and who was there with the entirety of her skills for that young mother and her baby. In turn, she needed and deserved visible, strong support. I fervently wish that practising midwives had also been in court as a presence for her.

Jo Murphy-Lawless

Reference

1. Sheeran, Bridget (2007) The Journey to Hospital. AIMS Journal, Volume 19, No 4, 2007/2008.

Stop Press

AIMS reported the case of Deborah Purdue, AIMS Journal Vol 21 No 3. Debs was restored to the register after the Sanction Only was reviewed in February 2010 (see NMC Website www.nmc-uk.org). Debs has a year's Conditions of Practice to do incorporating 450 hours of Supervised Practice (equivalent to three months unpaid.) North Dorset Hospitals Trust Maternity Unit are providing 'rehabilitation'. Debs told AIMS, "I have continued to have wonderful support from all at the Unit, especially the Head of Midwifery, Christine Voce, and my own supervisor, Carole Hedley. I feel the NMC should have a fund to support Supervised Practice for the midwives. Even expenses would help. I hope to have the Supervised Practice completed by September, and will then continue on the midwifery bank and perhaps apply for a job. The whole process seems even more painful in retrospect, but it is over. And I am moving forward."

Continuity of care?

Caseload midwife from Powys, *Anita Timmis,* looks at what is important to women

Midwifery research evidence concerning both safety and effectiveness shows that 'innovative' or midwife led forms of care are as safe and effective as 'traditional' care. In fact they often result in better childbirth outcomes and women are consequently more satisfied with their care[1,2,3] as they allow the midwife to make the woman the focus rather than the institution that employs her.

Normal birth as a fundamental right or choice is gradually being taken away from women and replaced with technology and medical intervention[4] and the art of midwifery, and all it represents, is disappearing as a consequence.[5] The recent synthesis of midwifery practice from a female orientated discipline into a predominantly male managed profession means that 'woman centred care' is not wholly directed by providers who understand the female psyche and this has resulted in some oppressive situations for women in the name of safety and convenience.[6,7,8,9] However, even when women are offered a choice, they will often continue to choose what they know and therefore policy makers maintain the status quo.[10] It is only perhaps where a different pattern of care exists and women are able to make comparisons, that they can exercise true choice.

Consistent messages convey that women are not happy with fragmentation, inconsistency, long waiting times in busy clinics and being treated like a number.[11,4] With the shortage of midwives in the current climate, the consequence of reinstating the focus back to women could suggest an increased workload for existing midwives or an increase in costs from employing more midwives. The House of Commons Health Care Committee[12] dispute this, claiming trusts that nurture midwifery practice and encourage midwives to practise continuity of care do not have problems with retention and midwife shortages. They claim that birth having become increasingly dependent on medicalisation and technology has resulted in a need for obstetric nurses rather than midwives and this is the reason that skilled midwives leave the profession.

Midwives who have control over their workload, such as caseload midwives, report significantly lower levels of stress than midwives providing other models of care[13] as they have more flexibility to respond to women's individual needs. Midwives can be truly autonomous practitioners, free from constraints of 'the institution' and more able to focus on the woman.[14,15] Having time to form relationships with women results in midwives valuing continuity of care as much as women and experiencing increased levels of clinical freedom and accountability of practice.

The midwives of the Albany Midwifery Practice had a shared philosophy that the fundamental role of the midwife is to be an advocate for women. They ensure women in their care are given the opportunity to have a good understanding of pregnancy and labour and they nurture confidence in women's ability to give birth and become mothers. Above all, they consider birth as normal. Home is advocated as a safe place to labour and to give birth for uncomplicated pregnancies. The Albany Practice is run from the heart of the community, providing continuity of midwifery care, with known midwives to local women, with the emphasis placed on community support. Outcomes from the Albany are excellent. Care is easily accessible and it centres on the development of relationships, the outcome of which is a high level of trust as the patient/professional barriers are broken down through kindness and compassion.

the Department of Health describes Albany as a 'centre of excellence'

The Cochrane Collaboration Review[3] consistently showed that women who experienced midwife led models of care experienced benefits and more positive outcomes. It concluded that all women of both low and high risk should be offered midwife led care and women should be encouraged to request it. This is reiterated by the Department of Health[16] who describe Albany as a 'centre of excellence' and recommend that all women, wherever they live, should be offered the option of a named midwife model of care.

An American study of a birth centre in the Bronx[8] compared women's previous birth experiences in a technocratic hospital system with a midwife led free-standing birth centre. This study served to illustrate the power inequalities when the medical model of care and its lack of choice and control conflicted with oppressed women's needs for respect and control of their birth environment. While early participants of the birth centre came out of curiosity, it was soon being recommended and because of its convenient location, it was accessible to women in the locality. Similar to the Albany Practice, the responsive and respectful environment focused on interpersonal relationships that valued the women and their families. As one woman said when she returned to the centre, 'They remembered my name.' Women learned that pregnancy and birth were normal physiological processes and wanted to return for care.

Nicky Leap[17] describes a philosophy of 'the less we do, the more we give' whereby the care-giver shifts the control of power to the woman. Women frequently regarded their previous hospital births as overwhelmingly

interventionist; the subsequent loss of control angered them. Access to health was helped by the midwives encouraging women to learn about their bodies in relation to pregnancy and birth, again a scheme employed by Albany midwives. What is clear from the women's description of hospital birth is that there was an absence of an advocate for them, but despite their negative experiences they were morally required to continue receiving care from the technocratic system. Women who were assertive enough to challenge this were subjected to scaremongering and warned that they would be held responsible for poor outcomes. When asked what the birth centre gave to her, a woman replied, 'My body. The hospital took it away and the birth centre gives it back.'

Mary Cronk[18] discusses the power base between women and midwives and identifies the Midwives Act of 1902 and the arrival of the National Health Service in 1948 as responsible in taking the power away from women. 'Professionals' became the experts and district midwives were brought under the same employer as the hospital midwives and expected to obey its policies. Home birth was phased out and the midwife-woman dynamic changed. Women have become trapped in a passive role as the midwife now has to balance the needs of the institution against the needs of the woman.[19] Bringing care back into the community allows the social dimension of care to be redefined and emphasis switches back from a role-based to a personally-based relationship.[20]

Support for women in labour is most effective from untrained lay women when the lay women come from the same neighbourhood as the labouring women and are not seen as part of the hospital hierarchy.[21] This generates a sense of familiarity and trust which, as a consequence, improves communication and feelings of control. The personal support the labouring women receive conveys messages of concern for and value of the woman as an individual.

Evidence shows that continuous care can make a difference to women's psychological predisposition to trust.[22,23] Continuous care can build confidence by the carer always being there for the cared-for. This is recognised as the 'Hawthorn effect'.[24] In having time to get to know and understand a woman and her circumstances, the carer is able to identify where confidence is lacking and build on it.

Continuity and trust generate effective communication. Advice that is trusted is more likely to be acted on and women are more likely to divulge sensitive information to someone they trust. This can pre-empt a breakdown in communication and prevent vulnerable women falling through the gaps when care is fragmented.[22] When care is fragmented, these components are what women say is missing. There is a danger of limiting the definition of continuity; it is very complex and perhaps we should not place value on continuity for its own sake, rather value what follows on from continuity: consistent quality care from someone who women can trust. What appears to matter most to women is that they should feel that their carers are competent and that they care about them.[24]

Understanding and measuring women's satisfaction with their maternity care is complex but is an important outcome of the childbirth continuum, having major implications for women's future well-being and for the mother-baby relationship. In spite of care providers and the government acknowledging this, little has changed regarding the provision of 'woman centred care' models.

Being satisfied is closely linked to expectations; if women do not hold very high expectations of maternity services, they may be very satisfied with what may have been very poor care. Also, what women deem as important may not concur with what care providers consider to be important.[4,25] Organisation, structure and experiences may affect women's perceptions and the nature of the mother-midwife relationship could be of paramount importance in ensuring maternal satisfaction.

The outcomes from the Albany Practice clearly illustrate the positive impact that this model of care has on the health and consequential psycho-social well-being of women: *'… if this model of care was compared to therapy it would be considered negligent not to prescribe it routinely to pregnant women.'*[26]

Despite the government recognising that all women should receive continuity of care, little has changed regarding the implementation of midwifery led models. The facilities were already in place at Albany; the midwives had the motivation to make that change and to make it happen. Whilst we can conclude from the evidence that good outcomes are a result of continuity of care, we can only hope this will serve to facilitate the implementation of such models of care becoming the rule rather than the exception. Sadly, in the current climate, it appears that rather the reverse is happening.

Anita Timmis

Thanks to Carmen Anderson, Tutor, Keele University

normal delivery is one without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery.

The Information Centre for health and social care, Maternity Statistics, England: 2007-08. Statistical Bulletin 2009. www.ic.nhs.uk

'It's about recognising that childbirth is a normal part of women's lives and a normal part of their family … My aim is achieved through continuity, and an approach that empowers women through birth to their future mothering. Making them feel good about the experience and how that helps them become a mother through their culture. Continuity is a way to deliver that philosophy more easily … it is a shared philosophy'

Albany Midwife

References

1. Green, J.M., Renfrew, M.J., & Curtis, P.A. (2000). Continuity of carer: what matters to women? A review of the evidence. Midwifery. 16, 186-196

2. Sandall, J., Davies, J., & Warwick, C. (2001). Evaluation of the Albany Midwifery Practice: Final Report March 2001. London: King's College Hospital

3. Hatem, M., Sandall, J., Devane, D., Soltani, H. & Gates, S. (2008).

Midwife-led versus other models of care for childbearing women. Cochrane Database of Systematic Reviews 2008, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub2.
4. Bones, E. (2005). The true cost of the centralisation of maternity services. MIDIRS Midwifery Digest 15 (4) 559-564
5. Downe, S., & McCourt, C. (2008). From being to becoming: reconstructing childbirth knowledges. In Downe, S. (Ed). Normal Childbirth: Evidence and Debate. (pp 3-27). Edinburgh: Churchill Livingstone
6. Dick-Read, G. (2004). Childbirth without fear. London: Pinter & Martin
7. Odent, M. (2008). Birth Reborn: What Childbirth Should Be. London: Cambridge University Press
8. Werner-Esposito, N. (1999). Marginalized women's comparisons of their hospital and free standing birth centre experiences: A contrast of inner-city birthing systems. Health Care for Women International. 20, 111-126
9. Rees, C. (2003). Introduction to Research for Midwives. Edinburgh: Books for Midwives
10. Robinson, J. (2003). The pseudo-choice game. British Journal of Midwifery. 11 (7) 424
11. Flint, C., Poulengeris, P., & Grant, A. (1989). The "Know Your Midwife" scheme - a randomised trial of continuity of care by a team of midwives. Midwifery 5, 11-16
12. House of Commons. (1992). Maternity Services Winterton Report. London: HMSO
13. Andrews, S., Brown, L., Bowman, L., Price, L., & Taylor, R. (2006). Caseload Midwifery: A Review. Midwifery Matters. Spring 108, 15-20
14. Edwards, N. (2008). Safety in birth: the contextual conundrums faced by women in a "risk society", driven by neoliberal policies. MIDIRS Midwifery Digest. 18 (4) 463-470
15. Thorgen, A., & Crang-Svalenius, E. (2009). Birth Centres in the East Midlands: views and experiences of midwives. British Journal of Midwifery. 17 (3) 144-151
16. House of Commons Health Committee. (2003). Inequalities in Access to Maternity Services. Eighth Report of Session 2002-03. London: The Stationery Office
17. Leap, N. (2000). The Less We Do, the More We Give. In: Kirkham, M. (Ed). The midwife-mother relationship. (pp 1-18). London: Macmillan Press Ltd
18. Cronk, M. (2000). The Midwife: A Professional Servant? In: Kirkham, M. (Ed). The midwife-mother relationship. (pp 19-27). London: Macmillan Press Ltd
19. Edwards, A. (2008). Place of birth: can "Maternity Matters" really deliver choice? British Journal of Midwifery. 16 (12) 771-775
20. Wilkins, R. (2000). Poor Relations: The Paucity of the Professional Paradigm. In Kirkham, M. (Ed). The midwife-mother relationship. (pp 28-52). London: Macmillan Press Ltd
21. Rosen, P. (2004). Supporting Women in Labour: Analysis of Different Types of Caregivers. Journal of Midwifery & Women's Health. 49 (1) 24-31
22. Huber, U., & Sandall, J. (2006). Continuity and Trust in the Context of Maternity Care and Breast feeding. MIDIRS Midwifery Digest 16 (4) 445-449
23. Hodnett, E.D., Gates, S., Hofmeyr, G.J., & Sakala, C. (2007). Continuous support for women during childbirth. Cochrane Database of Systematic Reviews. 2007, Issue 3. Art No: CD003766. DOI. 10. 1002/14651858.CD003766.pub2.
24. Green, J.M., Curtis, P., Price, H., & Renfrew, M.J. (1998). Continuing To Care. The organization of midwifery services in the UK: a structured review of the evidence. Cheshire: Books for Midwives
25. Wickham, S. (2006). Appraising Research Into Childbirth: An Interactive Workbook. London: Elsevier
26. Rosser, J. (2003). How do the Albany midwives do it? MIDIRS Midwifery Digest. 13 (2) 251-257

Outcomes from the Albany Practice

Caseload Midwifery Care versus Traditional Care from King's College Hospital Trust

	Albany[1]	King's	UK Average
Normal birth rate	77%	63%[1]	46.7%[2(2006)]
Home birth	42%	7%[1]	2.84%[2(2008)]
Inductions of labour	5%	16.4%[2(2008)]	20.2%[3(2008)]
Perinatal mortality	4.9%	11.4%[1]	7.7%[3(2008)]
Caesarean section	14.4%	24.1%[2(2008)]	24.6%[3(2008)]
Instrumental deliveries	5%	14.1%[2(2008)]	12.1%[3(2008)]
Augmentation	0%	20%[1]	not available
Episiotomy	3%	15%[1]	14%[3(2008)]
Use of pool	13%	0.2%[1]	not available
Entonox	10%	61%[1]	not available
Epidural	17%	35%[1]	*
Pethidine	1%	29%[1]	not available
No pharmacological pain relief	69%	16%[1]	not available
Intact perineum	47%	31%[1]	not available
Breastfeeding at birth	93%	not available	78.2%[3(2008)]
Breastfeeding at 28 days postpartum	70%	not available	35% [(at 1 week)3]
Attended in labour by a known midwife	98%	not available	not available

* 16.8% for those where this was recorded, but not recorded for 23.6% of women (2008-09)(HES)
1. Albany Data 2. Birth Choice UK 3. HES

Breech Home Birth of Lilly May Pawlak

Midwife *Rose Pride* shares her powerful birth experience

I 'd had the 'perfect' pregnancy throughout, so it was a bit of a shock to discover my baby was breech at nearly 37 weeks. Our amazing midwife Lisa tried to downplay it and said she could be wrong, and we could have a scan to check, if I wanted, but I knew she was breech, I didn't need a scan to tell me.

All of a sudden I felt like my 'plans' had been shattered and taken away from me, until my partner Brooke simply said, 'So what? Babies come out breech.'

I have been surrounded by breech babies - Brooke, a twin, was breech (vaginally) and my two nephews were also breech, but both were diagnosed late in labour (fully dilated and 7cm), in the hospital so they were born via Caesarean section!

Knowing that Lisa had experience in breech birth and her and Brooke's positive attitude allowed me to refocus, and for the next two weeks or so I tried everything to turn my baby. But deep down I knew she was exactly where she was meant to be! I guess that is why I didn't want an ECV (where an obstetrician tries to manually turn the baby from the outside). It was a huge relief when I finally decided to stop doing my bum-in-the-air positions, Moxa etc, because it allowed me fully to accept that I was having a breech baby!

Lisa discussed all of our options with us, and an elective caesarean was never in the thought process, so it was a decision whether to stay at home or plan a hospital breech birth. As soon as Lisa began talking about what may happen in the hospital, with their 'protocols' etc, I began to feel really nervous and scared, so my decision was already made: we would continue with the home birth. For me, I knew that if I went to hospital, my labour would not progress 'normally' and I would be bullied into having continuous fetal monitoring and an epidural 'just-in-case', and that Lisa would no longer be my midwife. That scared me much more than the (small) risks of an active breech birth at home. So to give my body and baby the best chance of a vaginal birth, I knew the only place to be was at home with my supportive team and experienced midwife.

I felt my first contraction at about 10pm on Tuesday 1st May. I had just gone to bed so I tried to rest as much as possible, but it was obvious there would be no rest as the contractions were only four minutes apart already! My wheat pack helped for about one and a half contractions I think! I continued to lie in bed and whenever I got a contraction I would have to wiggle around and at the height of each contraction I would need to be up on my all fours. Brooke was still asleep, but I thought 'don't tell him, he will get way too excited, but I want him to see how much it hurts! No, leave him, I will need him to be fresh when things start happening.'

The only comfortable position I could find was kneeling over the edge of the bed, so that was where I stayed for a couple of hours, as the pains got longer and stronger. Brooke still hadn't really realised things were happening, but I didn't care anymore, because I was focusing on my breathing a lot now, thanks to my Yoga practice.

I had to go to the toilet, and finally, after weeks of waiting for it, there was my 'show'. Woo Hoo. I was very excited, I could give myself permission to accept that this really was labour. I thought that if I down played everything then I wouldn't be disappointed if my labour was not as far along as I thought. Right, time to tell Brooke now! It was now midnight. Minutes after returning to the edge of the bed, and waterproofing the (cream) carpet, my waters broke. I found this a relief as I could really feel the forewaters bulging and it felt quite uncomfortable during the contractions. As I expected, there was thin meconium in the waters, but I always knew Lilly was OK because I could feel her moving lots.

I always knew Lilly was OK

Things really started happening now, but I still felt very much in control and coping with the pain fine. We decided to start using the TENS machine because you are meant to start using it as soon as labour starts, for maximum benefit. However we soon discovered the new cord they sent me (because the other one was faulty) didn't fit the machine! Aargh! So I only had one set of pads instead of two. 'Don't worry, I'll fix it,' says Brooke, as he scurries to his tool kit to save the day. It was quite comical, and I remember actually laughing.

Picture a naked pregnant woman in strong labour, moaning and groaning, leaning over the kitchen counter, and her man with his tools trying to fix an electrical machine! I really appreciated the effort, but just stuck with the one set. Despite this, the TENS worked quite well for me.

At 1am I found myself sitting on the toilet constantly. I kept draining lots of fluid and meconium, which was not pleasant. I also had a vomit and a fresh bloody show, which the midwife within was saying, 'Yes, that's your 5cm vomit,' but I disregarded it, in case I wasn't progressing as fast as I thought or hoped I was. We never actually timed

the contractions, I didn't need to know how far apart they were or how long they were lasting, I just knew one way or another I would be having my baby.

At 1:30am Brooke wanted to call Lisa but I wouldn't let him, because I felt fine and I knew she had been up with other births (and I know what it's like to be on call!) I really didn't feel like I needed any extra support, I was coping well and in control and the TENS was all the pain relief I needed. Lisa was going to bring the birth pool, when I was in labour, but I actually didn't feel like I needed it, yet. I thought poor Brooke could do with some support, so I said to call Kathryn, our support person (also a midwife). It was only then things started to feel 'different'. Hard to explain, but I also thought I could start to feel some bowel pressure! Kat heard this on the phone and came straightaway.

Under instruction from Kat, Brooke then called Lisa. After just 3½ hours of labour I was in transition! This stage was fine for me, I just couldn't work out what I wanted to do, and so Brooke suggested kneeling forward onto our beanbags as I found this a very comfy position during my pregnancy.

Kat arrived at 2am and the bowel pressure was quite strong, but I was too scared to push before anyone arrived. I think Brooke was very relieved to see someone, because he knew how fast things were happening.

Kat gave me the amazing support and encouragement I needed, as I found the feeling quite scary initially. It literally felt like my baby was going to come out of my bum! The acupressure point on the bottom of my foot worked wonders for this. After another vomit I managed to refocus and just go with the feeling, knowing it would be over soon. I was very relieved when Lilly came down more and I could feel the pressure more in my vagina and less in my bottom. I now felt more in control and enjoyed pushing. Lisa arrived at about 2:40am, and I am sure Kat was relieved to see her as she had never birthed a breech baby before, and of course there was no equipment either!

I made Brooke call our other support person Lyn (my mother-in-law), as I didn't want her to miss the birth. I could hear Brooke casually telling her I was in labour, so come around, but I knew she would miss it if she didn't hurry, so between contractions I was yelling, 'Tell her … I'm … pushing.'

I hardly noticed Lisa arrive as I was so focused on pushing this baby out, whether she was there or not! I figured if I was going to push, I might as well give it all I've got and make the process quicker. There was obviously no need for any examinations, which I was happy with. I could hear the wonderful encouraging words of Lisa and Kat, who were perched at my bum with a torch! Lyn arrived as Lilly's foot was out.

Being a midwife myself, I know the 'normal' birth process, so I was finding it a little difficult not knowing what was happening, as it was quite an unusual feeling. It felt very 'bitsy' as her limbs were birthing. I kept asking Lisa, 'what was that?' I found it helpful knowing where I

Rose and Lilly

was up to. I was also waiting for the 'Ring of Fire' burning sensation, but luckily I never felt it. The sorest bit was getting her legs out as she was born left leg first, and then sat there with one leg down and one up. She then brought her right leg down and I pushed her out up to her belly button. As I was in a forward kneeling position, my bum was close to the floor, so Lilly was able to sit on the floor, legs crossed like a lady! With the next contraction her left arm was out followed by her right arm and her head then flew out. There was no pause for her head and certainly no concern about an 'entrapped head' which doctors are so worried about!

Lilly was born at 3:02am, on her due date, weighing 8lb, 5 hours after my first contraction. She came so quickly no one had time to catch her, so she tumbled to the floor, before Lisa passed her through my legs to me. We were prepared for a 'floppy' baby who may need some oxygen or resuscitation, but there in my arms was this gorgeous girl who was pink and screaming and perfect in every way. I was not going to let her go, and she quickly calmed down in my arms, against my chest. I remember looking at Brooke in total amazement that we had done it! We had our perfect baby, in the perfect setting, of our loving, warm home.

After I was helped off the floor, my placenta came quickly and easily, and it felt so nice to lie down and breastfeed my baby, and begin to get to know each other, in the privacy and intimacy of my home. But the nicest thing was all three of us snuggling up together in bed, just a few hours after she was born. Home birth just makes sense!

Some people may believe it's naive to think this, but I knew everything was going to go well, and now I could prove this to everyone who doubted my body, my baby or me. The most important lesson I have learnt through this journey is trust. I had to do a lot of thinking about what I wanted and why I wanted it and this finally made me realise 'Everything is Perfect.' My baby was breech for a reason and I trusted my baby and body to give birth just as I would have if Lilly was head down. I will forever be grateful to my amazing support team and especially Lisa, for guiding and supporting me through my amazing journey.

Rose Pride

Home Birth Bullying

Tabatha Pollock Ellam looks for a way to avoid a repeat of abuse during labour

I wanted to share my story with you to see what you think. I'm 33 weeks pregnant and seem to be up against opposition from my midwife for a home birth. I have not been put on the home birth list even though I stated at booking in that I wanted a home birth. She seems hostile to the idea and has already listed a thousand and one reasons why I may not be able to have one.

This is my third pregnancy and it has been uncomplicated. My first two labours were completely natural and uncomplicated, I didn't even need a stitch and breastfeeding came naturally. I had healthy babies of normal weight and a problem free post-natal period.

When my first baby was born in 2000 I was treated horrendously by the midwives (not the midwife who delivered my baby). After hours of slow labour, I could tell during the night that the baby was imminent and told the midwives (they where watching TV in the day room) but they refused to believe me or examine me and told me to go back to bed as it was the early hours of the morning. This continued for several hours, after which they stopped answering the nurse call button, which meant I was walking back and forth to the midwives in considerable pain.

I was then told to have a lavender bath. Nobody offered any assistance even though I was in terrible pain. I struggled to get out of the bath and was then told to clean the bath out with handsoap and water. I had to wash the bath out initially as it was used and dirty. Given the fact that my waters had already broken, this was directly putting me and my baby at risk.

After telling the midwives I was in terrible pain and the baby was coming, and that I was having contractions, I was told that I was not in labour; I was offered a paracetamol and told to walk up and down the corridors. I did this for an hour or so by which time it was 6:30 am. I then lost all patience and demanded to be sent to the labour ward. After several minutes of arguments, I was sent and upon the first examination was told I was nearly 8cm dilated.

After this I was told to 'shut up' because I was being too loud, even though I was in full-blown labour (I had always assumed that the one place you can shout out in pain is in the labour ward whist giving birth.)

The anaesthetist then told me, quite aggressively, that if I moved again while he tried to insert the epidural he would not give me pain relief and I would have to do without. I was doubled over and having continued contractions and could not help moving.

I did not wish to have a second birth in hospital after this. I was so traumatised, I did not have my second daughter until 2008. I had planned to give birth at my local birthing centre, so I went there after my waters had broken and I was having mild contractions. The first midwife was lovely and very supportive; I felt at home and was very happy with the midwife and the birth centre. It seemed very relaxed and I felt cared for. After several hours of my labour not progressing any further, I felt disappointed and with that a shift change came. I was sure I was to have another lovely midwife.

When I had been on the birth centre tour earlier on in my pregnancy, the midwives all seemed relaxed and positive, labour was natural. Unfortunately the midwife who had taken over was not very supportive and was rude to me and my partner. We got the distinct feeling we were not welcome (the feeling you may get when you have been invited out by a friend but other people had not personally invited you and you are not really welcome). She told me to go home as I was not in labour, she then quizzed me about my first labour and then asked, 'What pain relief?' I told her I had an epidural, she then asked, 'Why could you not cope?' I was livid and left immediately after this as I did not want this woman to deliver my baby.

We got the distinct feeling we were not welcome

I was then told, some hours later, once labour had established, that I could not give birth at the birth centre as my waters had been broken for over 24 hours.

It was not explained why, or what the dangers are, or why I would be at greater risk in the birth centre as opposed to the hospital. At this time the consultant maternity services were running alongside the birth centre, and with my first baby, the paediatrician did not examine my baby until the following afternoon to assess if any infection had occurred. What difference would this make in the birth centre?

Both my babies were full term and healthy, so why would I be considered high risk? My first labour was exactly the same and so were both my mother's two labours and my grandmother's 12 labours. I was distraught.

I ended up giving birth at the consultant unit again but I was more forthright this time and would not tolerate the same level of bullying.

However, I was left unattended and unexamined on a trolley for an hour upon arrival before I was examined by a midwife. She discovered I was 7cm dilated and I was taken to the labour ward. I was unable to have any pain

relief other than gas and air as I was too far progressed in labour by the time I finally got to the labour ward.

I was also told that I could have the same type of birth as at the birth centre by a naive student midwife, but I was MADE to lie down and TOLD I must have a fetal heart monitor even though I stated I wanted to have the active birth which I'd planned for. Lying down gave me terrible back ache; I wanted to be kneeling or on all fours but I was TOLD I must lie down.

I was left unattended and unexamined on a trolley for an hour

I was made to stay overnight as my waters had been broken for over 24 hours and told the baby was at risk of infection but nobody could explain exactly what this meant or what signs I should look for. I was devastated by the thought of staying over, which I was only told about at the last minute.

After giving birth I was understandably exhausted, I had not slept for over 72 hours. My partner asked to stay over (to sleep in the chair if necessary) to give me some rest but he was told NO flatly. I was so upset, I felt trapped and scared. I did not get any rest in the hospital as my baby was restless throughout the night. She was born in the morning and had slept most of the day. I nearly passed out with exhaustion several times while holding my baby and my only relief was that my partner was coming to get me at visiting time the next morning.

This is not how becoming a new mother should be remembered; these first hours with your new baby are so very precious.

I struggle to understand why some go into the care profession. I have witnessed an obvious lack of humanity and empathy by not just one but several midwives.

Speaking to other mothers over the years, I have found that I'm not in the minority. We are not cattle, we are fellow human beings. Why should mothers tolerate such treatment at such a desperately vulnerable time?

I feel let down by the NHS and have lost faith in hospitals and nursing staff on the whole after my experience and now have a fear of hospitals.

Stop Press

Consultant obstetrician Dr Matt Hewitt, who testified at the inquest of Baby Tagdh (see page 15) was at the centre of an inquest, held in Cork City on the 5th May 2010, on a five day old baby boy who suffered spinal cord and internal head injuries as a result of Hewitt's decision to apply Keilland's forceps on a woman who was fully dilated. A verdict of medical misadventure was recorded.

I feel very strongly about trying to help with improvements to maternity services in the UK and I feel angry at the services we all currently get. I have heard that countries considered third world in Europe have better maternity services than us but this does not really come as a surprise from my personal experience.

Maybe it's a little strong to say but I would rather give birth in a field over my local hospital.

I have written the hospital the following letter, and copied it to my MP:

Dear Sir,

I am expecting my baby on xxx and I am being attended by a midwife who seems hostile to the idea of a home birth and has already listed a thousand and one reasons why I may not be able to have one. The midwife clearly does not understand the principles of choice and informed consent as she has not even put me on the home birth list, even though I have made my intentions perfectly clear. I intend birthing at home and when I go into labour I expect a midwife to attend.

I am not willing to have another baby in hospital and suffer the kind of abuse that I was subjected to during my last labours; I have attached details.

I look forward to hearing what arrangements you are going to put in place at your earliest convenience.

John and Tabatha Pollock Ellam

Quotation Corner

I am so glad that midwives like them [Albany] exist, but for me, I couldn't find one [independent midwife] within an hour and a half's drive of my home.

I chose to birth unassisted because I could not get a midwife who shared my views of birth, my need to not have internal examinations, one who could respect my privacy and dignity without having to refer to protocols and policies like my poor community midwife had to. She didn't like it either, but had no choice in what her employers would let her offer!

All was fine, but I am sure it would not have been had I got the 'hospital birth at home' on offer from my local NHS trust. Please keep things moving forwards, don't let them go back.

Reviews

The Father's Home Birth Handbook

by Leah Hazard
Victoria Park Press
ISBN-10: 0956071104
ISBN-13: 978-0956071101
£9.99

I was so excited when I first heard about this book, as I run a home birth support group and I have come into contact with quite a few fathers who seem somewhat uneasy about home birth. I always thought how good it would be if I could refer them to a book that would give them the confidence to home birth and now I can. The Father's Home birth Handbook is a fantastic source of evidence-based information which I believe every father-to-be or birth partner should read.

The book starts off by looking at risk and responsibility because usually the first question on everyone's lips when they first think of home birth is, 'Is it safe?' Leah writes a very well-balanced view on the safety of home birth and hospital birth with lots of references to the available research. The book makes suggestions for establishing and maintaining a positive outlook and the many benefits that this mind set can have on the outcome of pregnancy, labour and birth.

A whole chapter of the book looks at the pros and cons of who to invite to the birth including midwives, doulas, children, friends and family. A section of this chapter is also dedicated to freebirth and includes a positive story from a couple who chose to go it alone.

Leah covers pleasure and pain including how to understand that the pain of labour is not like an illness - it is natural and in a normal undisturbed physiological birth the pain will be eased by a woman's own flow of oxytocin. This flow is best aided where a woman feels safe and comfortable. This chapter suggests how the father can create and enhance this birth space and help to ease discomfort with massage and other suggestions for pain relief including water, homeopathy and TENS Machine.

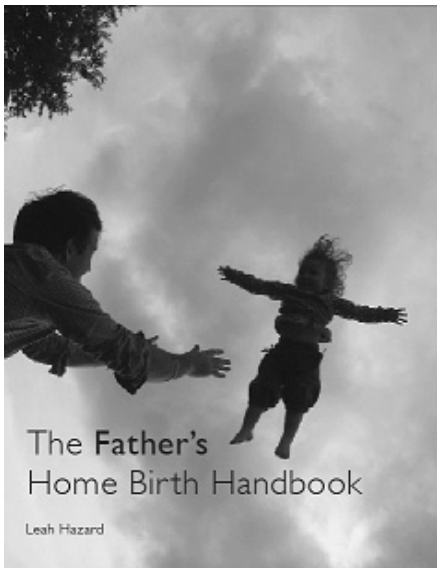
It talks about birth as a normal process, what fathers can expect the birth to be like and the different stages of labour and birth including the options available for birthing the placenta. There are quite a few birth stories told by other fathers which are very inspiring.

The book also looks at challenges and complications and how to deal with anything that might arise including premature labour, what if baby is overdue, a long labour, accidental unassisted birth, fetal distress, baby born with cord around neck, tears during birth and blood loss with lots of reassuring stories from other fathers who have successfully dealt with these kind of challenges.

The book is concluded with a chapter about what can happen after the birth and some of the ways that you might feel after the birth, for example if the birth doesn't go to plan the father might be left with feelings of guilt. Leah encourages fathers to talk about their feelings so that they are able to move on.

A book that I would definitely recommend.

Michelle Barnes



The Doula Book *- How a trained labour companion can help you have a shorter, easier and healthier birth*

by Klaus, Klaus & Kennell
Perseus Books: 2nd Edition 2002
ISBN-10: 0738206091
ISBN-13: 978-0738206097
£11.99

I loved this book! I've read many books dedicated to the subject of birth, breastfeeding, VBAC etc. but this was the first one written solely about doulas. It was incredibly useful to me when compiling my website as much of it looks at how a doula is of use to birthing parents. It compounded my ideas of exactly what a doula can do during labour - whilst I accept that simply by sitting quietly in the corner of the labour room the labouring woman can gain comfort from one's presence, I have always felt that many women would benefit from a more actively involved doula. Whilst reading the book, I was struck by how important it was felt by all for the doula to remain constantly by the mother's side, and how important it is to maintain physical contact, even if it's just to keep a hand on the mother's arm. I came away from my doula training course thinking that this view was wrong, and that it was more important to stay in the background so I'm very glad to find that this isn't necessarily the case. I think that if I hadn't read this book, I would have been less of a doula than my future clients deserve.

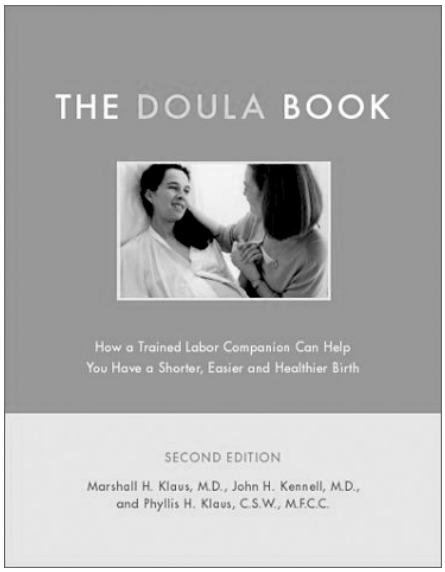
As someone who finds statistics comforting, it was great to read the studies done on the effects that doulas have on a multitude of levels, not only on the reduction in caesareans, which has always been my main interest, but on things like length of labour, longevity of breastfeeding, the reduction in the rates of postnatal depression and interestingly, the satisfaction with their partners after the birth. As so many men are not keen on the idea of their partners hiring a doula, I think that this information is hugely important and it's good to have something to refer back to if I'm asked for evidence to back up these statements.

I was very interested in the practical applications of doula skills too, especially those that actively involved the father - the Dangle and the Double Hip Squeeze spring to mind! It hadn't really occurred to me quite how physically demanding being a doula might be. There is a very good section on breastfeeding, and how by following a few simple instructions, the baby learns to latch itself on rather than the mother (or doula) 'getting' the baby latched on. As someone who has breastfed successfully for a long time herself, and as someone who was pretty much self-taught, it was eye-opening to read such a simple description of latching that would be so simple to put into practice with a new mum. I feel that I could explain myself very clearly now whereas before I could only have physically demonstrated how I would do it myself.

My favourite section of the book was the one outlining the doula's role during different stages of labour. There is a lot of specific advice and reminders of how you can best let the mother help herself by focusing on hers and her partner's needs, and I can see that this book will be a valuable part of my doula tool kit. I'm sure I will refer back to it time and time again as an aide memoire before a birth until such time that I feel confident enough in my abilities to do it instinctively.

I think that every doula should have this book on her bookshelf, no matter how many births she's attended. It's very comprehensive and answers all the questions that I never thought to ask on my training course.

Tina Coley



The Crucible

by Arthur Miller

Having studied this play at school, both as a work of literature and as a piece of American History, and having seen it performed a few times, I was quite unprepared for the shock of seeing it through fresh eyes.

What suddenly struck me whilst watching it this time, having spent a considerable part of the autumn working with investigations into Independent Midwives and the closure of the Albany Midwifery practice, was how close we really are to repeating the very same prejudicial and ignorant court system which operated in Salem in the late 1600s, described as 'one of the strangest and most awful chapters in human history'.

In Miller's account, recorded events are fleshed out to tell a story of mass hysteria and mistrust. In 1692 the town of Salem, in puritanical New England, was gripped by the fear that the authority of the church was losing control. People started to stray from the church, and some say that this is what fuelled the witch trials. Miller tells us how the small community of Salem is stirred into madness by superstition, paranoia and malice, culminating in the deaths of nineteen men and women and two dogs.

In this portrayal of the terrifying power of fear, mindless persecution and false accusations, Miller draws a chilling parallel between the Salem witch-hunt and Senator McCarthy's crusade against communism which caused widespread paranoia in 1950s America.

The parallel with the 'trial' of independent midwives at NMC fitness to practice hearings, and their treatment in the press is equally chilling. Midwives are being called to task for actions which are done in the best interests of the women in their care, rather than in the best interests of the system and the accepted 'normality' of birth.

Of course, with the physiologically normal (by the WHO definition) birth rate in the UK being somewhere round 10%, if even recorded, the popular acceptance of birth practice against which they are being judged may be what is seriously flawed.

When we judge our midwives supporting a woman in a home birth by the obstetric standards of a hospital with a caesarean section rate of 25%, whilst inaccurately telling women via the press and public perception that hospitals are the safest place to give birth, we are allowing those people who support health and normality to be judged in a climate of fear and mistrust. This is inevitably leading to them one by painful one leaving the profession or being driven out of practice.

Miller urged us to be careful about how we react. We cannot avoid involvement, we have personal responsibility. I think that the time has come for those of us who care about the future of midwifery, about birth for our daughters and granddaughters, to look at the lessons of history, and this play is a very good start.

Witch hunting in Salem, chilling, true and not far enough removed from today!

Vicki Williams

Do I get a choice?

This letter came to the AIMS helpline from a mum who does not meet her local birth centre criteria, AIMS wonders how much they vary. She clearly believes the government rhetoric and is saying, 'but surely I have the right to give birth where I choose?' However, if you don't meet birth centre criteria, you don't get in. The only place, it seems to us, you have a right to choose and they cannot deny you entry, is your own home as birthplace.

Dear AIMS

I am 40 years old and 35 weeks pregnant. I really need some advice.

Since the beginning of my pregnancy I've had the local Hospital listed on my green notes for my birth location - in their birth centre.

However, I went for a visit to the Birth Centre on Friday 20th November and I was literally there one minute!

she refused to allow me to go any further

The midwife who came to show me round said I had to have had a straight forward pregnancy (which I have.) She asked if it was my first baby and I told her it was my second and she asked about that birth and I told her I'd had pre-eclampsia at the end, in the 39th week. Where upon she refused to allow me to go any further. She just out right said I wouldn't be able to use the birth centre and would have to give birth in the consultant led maternity unit. This unit is only on the floor below, so it's not as if I'd be a million miles from medical 'help' if required. I did point out that just because I'd had pre-eclampsia before didn't mean I'd get it again, she disagreed and said they wouldn't book me in.

I had a traumatic, medicalised birth with my first child. A birth that left me with severe PND, that lasted for the first year of my daughter's life. I am in a panic about having to labour in the maternity unit, to the extent of having panic attacks at the thought of it.

Is this midwife's advice correct? I thought I had the right to give birth where I choose? I feel very strongly about not wanting to go into the maternity unit. I really (in my heart of hearts) want a home birth, but I was being sensible choosing the birth centre - mainly because it is only one floor above the consultant led maternity unit.

Please can you advise me on my rights - or if I actually have any, or whether I am just going to have to accept the maternity unit as a fait accompli?

Many thanks in advance

Melanie Pollitt

AIMS replied:

Dear Melanie,

I am sorry to hear that you have not been encouraged to have your baby in the birth centre, and I agree that pre-eclampsia with your first baby does not suggest that it will happen again, (although if you had changed partners that might make a difference.)

You have a few options, you could ask to speak to the midwife in charge of the birth centre and ask to see the evidence that suggests that you are at a higher risk than anyone else. You could go to the supervisor of the midwife you saw since you don't agree with her, as supervisors have as part of their role the task of intervening in this kind of matter. You could, of course, say that if you are not accepted in the birth centre you will book a home birth as you have every right to. This may cause a change of mind or you could end up with a home birth which is what you would prefer.

This is not an easy position to be in as the last thing you want to do is to have to argue with your potential birth attendants but you are well within your rights to question this decision.

You might find our website helpful. Do keep in touch with us and let us know what happens next, with good wishes.

AIMS

There is some flexibility

We spoke on the phone a couple of weeks ago when I was 37+4 and trying to arrange midwifery cover for a home birth. I just wanted to let you know what happened.

I managed to speak to a supervisor of midwives who agreed that it was arbitrary and ridiculous to not provide me with cover for the sake of being a few days before 38 weeks. She arranged for me to have midwives on call and for the home birth kit to be delivered to my house, she was incredibly supportive as was the local authority supervisory midwifery officer. As it happened my contractions completely stopped and didn't start up again for another two weeks but I'm pleased to say my daughter Darcy was born at home on the 10th of November after a very straight forward and fast one hour labour. I just wanted to thank you for the support and excellent advice you gave me on the phone that day.

I'm a member of my local maternity services liaison committee and I intend to raise the issue of midwife cover from 37 weeks at our next meeting. I hope that in the future other women in my area won't have to face such stress to arrange care.

Emma Davidson

JOURNALS & BOOKS

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

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

Birth After Caesarean by Jenny Lesley: Information regarding choices, including 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

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

Breech Birth – What are my options? by Jane Evans: one of the most experienced midwives in Breech Birth. 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

Delivering Your Placenta: The Third Stage by Nadine Edwards: The merits and disadvantages of a 'managed' (with drugs) vs a more natural third stage £5.00

Home Birth – A Practical Guide (4th Edition) by Nicky Wesson
AIMS has replaced Choosing a Home Birth with this fully revised and updated edition. Nicky tells us what the research says, what midwives think, what mothers want, what babies need. Every sentence is packed with interest. It is relevant to everyone who is pregnant, even if you 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: 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

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

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

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

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

OCCASIONAL PAPERS

AIMS' Comments on the NHS Complaints Procedures: Problems complainants have with the review system, case note access, time limits; complainant's emotional needs (1993) £2.50

Birth is a Normal Process: A Mother's Perspective: How medicalised hospital birth undermines normal childbirth £2.50

Drugs in Labour and Birth - What Effect Do They Have 20 Years Hence? by Beverley Beech: the potential long-term adverse effects on the baby of the many drugs used in labour £2.50

History of AIMS 1960 -1990: A résumé of AIMS' activities and the campaigns it has undertaken over the last 30 years £2.50

Pain Relief in Labour: Women's Perspectives: Covers how hospitalised childbirth practices result in women needing drugs for pain relief £2.50

Procedures Related to Adverse Clinical Incidents and Outcomes in Medical Care: AIMS' response to the House of Commons Health Committee on problems with the current complaints procedures in maternity care £2.50

Risks of Caesarean Section: Research papers on the risks of caesareans, which can be used as a basis for further study of the subject £2.50

The Benefits and Hazards of Obstetric Care: by Beverley Beech, this discusses how obstetric care may lead to poor outcomes for both babies and their mothers £2.50

The Mirage of Choice: The word 'choice' often masks an agenda to persuade women to give birth in hospital despite evidence of the dangers and risks to both mothers and babies £2.50

The Pregnant Woman's Need for Information: Medicine Use in Pregnancy and Birth: Paper presented at the 13th European Symposium on Clinical Pharmacology Evaluation in Drug Control; discusses drug usage in pregnancy and birth, and the amount of information and advice given to women £2.50

Ultrasound - Weighing the Propaganda Against the Facts: A paper that questions the value of routine ultrasound screening, based on the scientific evidence reported since Ultrasound? Unsound! was published £2.50

MISCELLANEOUS

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

A Charter For Ethical Research in Maternity Care: Written by AIMS and the National Childbirth Trust, this sets out professional guidelines to help women make informed choices about participating in medical research £1.00

Do Not Disturb: Bonding in Progress: Mothers and babies need time to get to know each other. This simple but effective sign can be hung on doors or beds to ensure others get the message £1.00

Maternity Statistics Questionnaire: Any woman wanting information on her local maternity-unit practices can send this questionnaire to their local unit. Please then post a copy of your unit's reply to The AIMS Chair, Beverley Lawrence Beech, who will add the information to AIMS' compendium of hospital practices £1.00

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

T-shirts: This is your chance to show some attitude – everyone wants to know where they stand – now you can tell them! Quality 100% white cotton T-shirts printed with ***'Don't Mess With Me! I am an AIMS Member.'*** For campaigning or for during your pregnancy. Sizes M (40" round bust and waist) L (44" round bust and waist) XXL (52" round bust and waist). £15.00 each

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

Publications Pamphlet FREE

AIMS PUBLICATIONS ORDER FORM

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

(Please print clearly in block capitals)

Item	Price	Qty	Total

Don't forget to add the size of your T-shirt

Sub total .....

Postage and Packing .....

For orders up to £20 add £2
Between £20 and £30 add £3
For orders over £30 add £4

Donation .....

Total .....

Name .....
Title .....
Address .....
.....
..... Postcode .....
Your email address .....

Are you and AIMS Member? Yes / No

Send cheque/postal order payable to AIMS to: Shane Ridley
Manor Barn, Thurloxton, Taunton, Somerset TA2 8RH

Noticeboard

AIMS Meeting Dates

The committee will be getting together on:

16th July in Abergavenny

17th July in Birmingham - AIMS AGM

25th September in Dublin

16th October - Anniversary Lunch, London

13th November in Camberley

All AIMS members are invited to join us. If you would like to come to a meeting please email secretary@aims.org.uk for times and venues.

Wysewomen Workshops

Workshops for all of those working around birth who like to think outside the box

Friday 28th May, 2010
London

Friday 11th June, 2010
Edinburgh

Friday 25th June, 2010
London

email:
nicolagoodall@gmail.com

website:
sites.google.com/site/wysewomen

Birthing in Love: Everyone's Right

Midwifery Today & Domashniy (Home Child) Joint conference
Wednesday 9th - Sunday 13th June 2010
Moscow, Russia
www.midwiferytoday.com/conferences/Russia2010

Birth Workshop

Use of water

Saturday 3rd July 2010 (half day)
Woodley Park Centre, Skelmersdale, WN8 6UQ
email: workshops@bluelagoonbirthpools.co.uk
www.bluelagoonbirthpools.co.uk/Workshops.htm

An increase of £5 was agreed at the 2007 AIMS AGM which has been implemented from 1st January 2008. The membership form below contains the new rates. Thank you for all your support.

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