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Midwifery under threat

Who gives the information and who gives consent?

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Midwifery – running down the drain

Beverley Beech looks at the threat to birthing choice in the UK

In 1993 a Parliamentary Report on maternity services, the Winterton Report,[1] was published. Those of us who had been campaigning for changes in maternity care jumped for joy (quite literally - the MPs had accepted all but one of the points made in the AIMS' evidence). At last, they produced a Report that highlighted poverty as the major cause of poor birth outcomes and lack of choice. It recognised the social and psychological, as well as physical impact of birth on women and families and called for women to be enabled to make decisions about their care and births, through the provision of less medicalised midwifery care, with midwives taking a leading role in maternity service provision. It recognised that maternity care was over-medicalised, and it concluded that *'there is a strong desire among women for the provision of continuity of care and carer throughout pregnancy and childbirth, and that the majority of them regard midwives as the group best placed and equipped to provide this.'*

(page xv, para 49)

The Government at the time, however, decided to focus on choice - an issue that is still absolutely central to current maternity care. In 2007, Maternity Matters[2] 'guaranteed' that by the end of 2009 women would have choice of midwifery care and place of birth. With the end of the year almost upon us these guarantees appear somewhat hollow. The latest National Childbirth Trust survey[3] revealed that 95.8% of women do not have real choice between home birth with a midwife, a local midwifery unit (birth centre) or an obstetric unit, and 89% of women live in areas that do not offer the choice of a home birth with a midwife (see page 12.)

Over the years, it has become startlingly obvious that those women who truly are able to exercise choice are mostly those who are cared for by Independent Midwives and midwives working in the community as, for example, in the Albany Practice in Peckham, South London. For those midwives the issue of choice, respecting women's views, and supporting them to birth in surroundings where they feel comfortable are absolutely central. The Albany's stunningly positive outcomes show the impact of careful, continuous, midwifery input which empowers women to make informed decisions. This is also the basis of independent midwifery care and care from midwives who truly respect women and enable them to make decisions. But this ethos appears to be particularly threatening to those working within a system of care that pays lip service to choice and autonomy leading to punitive action being taken against those who do not subscribe to the medically dominated system of care.

While the government appears to be keen to encourage change which will enhance midwifery practice, the forces preventing this from happening, if anything, appear to be even greater. The NHS Information Centre's latest figures[4] show that national caesarean section statistics have increased yet again to an average of 24.6%, with Imperial College Healthcare Trust achieving the deplorable level of 33.1%. (The World Health Organisation has stated that a caesarean rate over 10% does not improve the health of mothers or babies).

Trusts are paid £2,579 for each caesarean section (and £3,626 for one with complications) compared with £1,174 for a vaginal birth. This means that should a Trust vigorously promote normal birth, significantly reduce the numbers of unnecessary caesarean sections, or build more free-standing midwifery units, it would lose substantial amounts of money. Instead of focusing on the relationship between mother and midwife, supporting midwives to provide the skilled midwifery input that has been shown to improve outcomes for women and babies, and increasing the numbers of midwives, the focus has been on improving technological input and team work in an institutional setting.

The King's Fund in 2008[6] reported that an estimated 62,746 safety 'incidents' were recorded in English maternity units between June 2006 and May 2007, with moderate harm in 11% (6,902) of cases; severe harm in 1.5% (941) cases and death in 0.5% (314) cases.[5] At the same time, despite many midwives being unemployed, the maternity services, in England, are 4,000 midwives short, making it impossible for midwives to provide the kind of continuity of care that is needed. This, AIMS believes, is a major element in increased risk and poorer outcomes. Overstretched services, hierarchical structures, and services that do not focus on individual women, cannot provide the safest care possible: instead it provides an environment that encourages and perpetuates bullying of both midwives and women.

Institutionalised bullying

All over the UK midwives are struggling to improve care but they are doing so in the face of a complex interaction between the State running down our NHS services,[6] a hierarchical structure, and a conflict between a social and a medical model of birth. Both midwives and doctors are forced into a system which cannot respect individual initiatives but needs people to conform to the organisational norms and established authority in order to cope with lack of resources and understaffing.[7] Such a system allows institutionalised bullying to flourish. Over the years there has been considerable concern about

bullying in midwifery within the services and respected senior midwives, such as Mavis Kirkham and Ruth Deery[8] have written extensively on this problem. However, bullying has become embedded in many of the structures within and surrounding the NHS - extending to supervision and the regulatory bodies.

Double standards

Examination of the cases that have been reported to the Nursing and Midwifery Council (NMC) reveals a disproportionate number of independent midwives, although community midwives are also included in the numbers. Those of us who have assisted women in formulating complaints about their care, and who have followed complaints made by women and health practitioners, are struck by the double standards that appear to exist: when women complain about care they received in hospital following untoward incidents, inquiries are likely to remain internal to the hospital and staff involved are most unlikely to be reported to their regulatory bodies. However, when untoward incidents happen in the community, it is very much more likely that the midwife(s) involved will be referred to the NMC. Of course, AIMS would be just as concerned about inappropriate or poor care from an independent or community midwife as one in the hospital, but what we are concerned with is an equal standard of justice for all.

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In Wales, Clare Fisher, a skilled and committed midwife, has been battling against the senior midwives in Health Professions Wales (HPW). From the letters between her and the senior midwives, and from the transcripts of the Nursing and Midwifery Council (NMC) cases, there appears to be a concerted effort to remove the only independent midwife in Wales from the midwifery register. Her case is a disgraceful example of persistent bullying and maladministration (reported more fully on page 6). Despite a critical Ombudsman report, and repeated complaints to the NMC, those involved are still in place and continue their bullying tactics.

In Dorset, midwife Deborah Purdue was struck off the Midwives' Register. While attending a woman at home during a planned home birth, she discovered that the baby was presenting by the breech and advised the woman to transfer to hospital where Debs handed her over to the care of the hospital staff. There is evidence that the baby was fit and healthy upon arrival at the hospital. It died several hours later following an obstetric breech extraction and extensive resuscitation. The subsequent investigation focused only on Debs' practice during the labour rather than into the hospital staff's management of the delivery itself. Given that mother and baby were well on arrival at hospital, this seems particularly perverse (see page 10).

In Scotland, during the Independent Midwife, Beatrice Carla's case, the chair of the NMC Conduct and Competence Committee spent considerable time advising the other members of the panel about relevant appropriate research and correcting their misconceptions about the benefits of medicalised, routinised care, especially about the use of fetal heart monitoring. It was clear that the lay member and the nurse erroneously believed that continuous monitoring of babies' heart beats must be associated with better outcomes, therefore, the more often the fetal heart is listened to, the better.

A major problem with the NMC is that midwives are being judged by hospital nurses, midwives who have little or no experience of community midwifery, (in Deb Purdue's case the 'due regard' midwife was a labour ward manager) and lay people who have even less understanding. Furthermore, the panels are not required to hear expert witnesses. The consequence is that the panel is either without midwifery expertise or, is reliant on the views of one midwife whose experience can be very out of date or inappropriate to the case being heard. In Clare Fisher's case the midwife panelist, Eunice Foster, repeatedly fell asleep.

Midwives who question routine medical practices, and who support women's decisions to avoid these, appear much more likely to receive sanctions. In addition, issues that would normally be dealt with through midwifery supervision at local level, when a midwife is employed by the NHS (such as note keeping and hand over procedures), frequently appear before the NMC when the midwife works independently.

The re-organisation of the NHS in 1974 transferred midwives from local authority employment to the NHS when they were increasingly required to work in hospitals. As a result, many midwives have lost their midwifery skills. While experienced home birth midwives are often expected to 'update' themselves by having a rotation to the consultant unit where they are 'updated' in obstetric interventions, there is no updating the unit's midwives by rotation to the home birth team where they could learn the skills of attending home births. While the NMC considers that all midwives are capable of practising autonomously and independently the reality is that hospitals' hierarchical management impose rules and regulations, protocols, and guidelines that are medically determined yet, at the same time, the midwives are expected to offer choice, one-to-one care, and respect women's decisions.

Bullying and suspending midwives

The institutionalisation of midwives and the hierarchichal system tolerates bullying and perpetuates the lack of understanding or acceptance of midwifery knowledge because this poses a serious threat to the medicalised service which encourages a fear and dislike of innovative midwives, 'tall poppies', who have to be cut down to size.

The latest example of undermining midwifery and midwives, and institutionalised bullying involves the midwives at the Albany Midwifery Practice, in Peckham, London. King's College Hospital initially, and without warning, suspended the home birth and home labour assessment services in October, and subsequently suspended from duty a long standing, highly experienced, Albany midwife and reported her to the NMC (the NMC has since thrown out the case.) King's then took the unprecedented action of suddenly terminating the contract with the Albany Midwifery Practice, amid huge protests from the community it serves (see page 21). As the perinatal mortality rate among babies looked after by the Albany Practice midwives is 4.9 per 1000, compared with 11.4 per 1000 for the locality and 7.7 nationally; and as the caesarean section rate is below 14.4 % compared with a caesarean section rate of 24.1% at King's (2008 figures), and while the breastfeeding rates among Albany mothers is consistently around 80% at 28 days - way above the local and national rates, the decision to withdraw the service is truly baffling.

Thorough investigations

When a mother or baby dies, or is seriously injured, it is right that there should be a thorough investigation to determine whether or not this was caused by incompetence, misadventure or was an unavoidable tragedy where everyone did the best that they could, but it appears that far too many of these 'investigations' are primarily designed to criticise a practitioner, invariably the midwife, and then use it as an opportunity to report her, or him, to the NMC. There appears to be an assumption that if the baby dies in hospital the staff will have done everything possible to prevent it, having carried out lots of interventions (many of which may have caused the problem in the first place); but when a baby dies at home the mother, midwife, or both, must be to blame.

Any enquiry is stressful for everyone concerned. Too often we have seen little or no support for the individual midwife involved in a difficult incident (as in Clare's case) and, not infrequently, we have learned that senior midwifery and medical colleagues make comments to the parents designed to alienate them from their midwife(s).

Length of time

Perhaps, one of the greatest injustices is the length of time these investigations and referrals take, and the failure of both the NMC and the Local Supervising Authorities to follow their own rules and regulations. The strain on the individuals and their families constitutes a breach of human rights.

In Deborah Purdue's case she was not suspended and continued to work for four years whilst awaiting her NMC hearing, only then to be struck off the register. Clearly, the local managers after their initial investigation did not consider her to be a risk to women and babies which makes the Conduct and Competence Committee's decision even more questionable.

Clare Fisher's case took the NMC nine hearings from January 2006 to May 2008, covering 19 days overall, to come to their questionable decision and impose a five year caution. (see page 6)

AIMS would support any Trust that suspended or disciplined an incompetent midwife or doctor who is a danger to the public, but it appears that too many hard-working, conscientious and competent midwives are being subjected to months, and even years, of uncertainty and further bullying while waiting for their cases to be heard.

British society generally accepts as authoritative the obstetric management of childbirth and midwives. There is an illusion that obstetricians understand normal childbirth, that women can choose the kind of care they want, and that midwives and doctors practice informed consent.[9] Few practitioners, however, understand that the other side of informed consent is the principle of informed refusal. Woe betide the woman who chooses to reject the medical model, who refuses to go into hospital and whose midwife is not willing to bully her into complying. Those midwives, whether working in the community or in hospital, too often find that really supporting women, enabling them to give birth without unnecessary interventions, and practising good midwifery care, is not supported and, should there be a less than optimal outcome, they will find themselves criticised and subjected to intense scrutiny that their hospital-based colleagues who conform rarely face.

This injustice will continue while the present system of birth practices, supervision and NMC hearings fail to address the tensions between holistic midwifery care and obstetric management.

Beverley Lawrence Beech

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Clare Fisher – the Welsh witch-hunt

AIMS Chair *Beverley Beech* reports

Clare Fisher qualified as a midwife in October 1993 and in 1994 came to work in Carmarthen. Following the arrival of Gillian Harris (Head of Midwifery) at Carmarthenshire NHS Trust Clare was subject to a series of investigations, comments and general bullying. In 1998 she made a formal complaint. Other midwives questioned the wisdom of this.

Six weeks later Clare found herself 'suspended from duty'. She did not return to the Trust for 22 months. In that time the midwives she worked with were informed that they should not contact her. Her Named Supervisor of Midwives neither contacted her nor offered any support during this period. When Clare was finally re-instated the Trust offered no reason for her suspension - and UNISON insisted that her fellow staff be informed that there had been no disciplinary procedures involved despite this enforced and prolonged absence.

In 2003 an NHS client, who was 35 weeks pregnant and had yet to write her birth plan, alleged that 'she feared' that Clare would not accept her wish for a hospital birth and believed that this had happened to other women. There followed a supervisory investigation to look at the home births undertaken by two midwifery teams. In reality it was a trawl through Clare's case notes (25 of the 30 notes examined were Clare's). The women who supported Clare were never interviewed, despite writing to say they wanted to be involved with the investigation. No evidence was produced supporting the allegation or that any other women had similar experiences, but despite this the investigation concluded that there was *'gross misconduct and gross negligence and that Clare should not be allowed to work within the community or in isolation.'*

A disciplinary hearing was to be held on the 17th April 2004, however Clare was off sick with stress and she notified the Trust that she could not attend and, furthermore, was still awaiting the documentation.

Carole Bell (Acting Head of Midwifery) forwarded the 'investigation file' to Gillian Harris who was on secondment to Health Professions Wales (HPW) who then forwarded it to Jean Keats (also at HPW) who had also been appointed to sit on the Trust's Disciplinary Hearing. The conflict of interest in these two roles does not seem to have occurred to Jean Keats - who suggested to the LSA that if Clare did not attend the disciplinary hearing she should be suspended from practice and reported to the Nursing and Midwifery Council (NMC), clearly having made a decision well ahead of the hearing.

Around this time Clare was told by her Union that the Trust intended to sack her and if they did so she would lose her pension rights and was advised to resign and the Trust would pay her in lieu of notice. The Trust assured her that this would then be the end of the matter. Clare formally resigned on 29th April 2004. She intended setting up as a midwife in independent practice - but before she could do so she received a letter from Dr Robyn Phillips (HPW) (May 7th 2004) stating that she was suspended from practice with immediate affect, and that her practice had been referred to the NMC.

On the 6th July 2004 the NMC held an Extraordinary Meeting of the Preliminary Proceedings Committee. The Committee concluded that 'it was not necessary to direct the interim suspension of your practice' and wrote to Clare informing her of this two days later. She was also told that the Committee would notify the LSA and understood that her suspension would be lifted. On the 12th July Robyn Phillips, despite being told by Clare that the suspension was lifted, wrote to her stating that the suspension was still in force (as she had not, allegedly, heard from the NMC). It was not until the 26th July that Robyn Phillips informed Clare that her suspension was lifted. Shortly afterward Clare miscarried her 6th baby, after five healthy pregnancies, an event which she believes was caused by the stress.

Around this time Carmarthenshire NHS Trust midwives were accepting an award from Princess Anne for 'promoting normality' in Wales. Clare who had attended more home births than any other midwife in the area was not invited and only found out about it afterwards.

After repeated requests for a meeting, and a threat to go to the press, on the 10th August 2004 Clare and her partner met with HPW. She wanted a full and frank discussion of why she had been referred to the NMC and why they failed to lift her suspension appropriately. Clare presented a list of questions but they were not answered. Instead HPW claimed that this meeting was *'to provide supportive supervised practice and ongoing contact with a named supervisor of midwives.'* Following this meeting Dr Phillips immediately began taking steps to replace Chris Withey, who was Clare's Named Supervisor of Midwives and with whom she had a good relationship, with Jean Keats - the supervisor who had only recently recommended to the LSA Clare's referral and suspension.

Chris Withey eventually withdrew as Clare's Named Supervisor – 'on advice received from HPW'. Dr Phillips then attempted to impose Supervised Practice on Clare – but was told by the NMC that she was not empowered to do so. Instead – and with her appointment as LSA MO made public in the October NMC magazine – Jean Keats was appointed as Clare's Named Supervisor of Midwives, yet another conflict of interest. Dr Phillips

failed to acknowledge that the Named SoM she was appointing had been so directly involved in the previous referral – and Mrs Keats has since stated that she was simply unaware that the midwife to whom she was now Named Supervisor was the same midwife that she had only recently recommended for suspension from practice and referred to the NMC.

Libellous notes

Clare had been concerned that the hand of Gillian Harris was behind these referrals despite HPW's denial. Her suspicions were confirmed when she received copies of the documents that had been forwarded to the NMC. They contained a libellous and dishonest handwritten note stating that 'She [Clare] had attend [sic] and signed the attendance form, lied to the investigating officer'. Clare recognised the distinctive handwriting as Gillian Harris's. This note only came to light the day before the hearing so Clare asked the NMC for copies of all the papers relating to her case as the copies forwarded to her by HPW and the copy held in their archives did not contain the note. Clare wrote to Dr Phillips asking her to investigate the author of the statement which she failed to do, so Clare wrote directly to Gillian Harris asking her to confirm her authorship. Despite a draft copy letter that is held in HPW archive denying her involvement, Gillian Harris did eventually write to confirm that she had added the hand written comment. There was no apology - instead she accused Clare of failing to draw attention to the matter at an earlier stage.

Planning ahead?

The NMC declined to proceed with the case against Clare but on the 7th September Robyn Phillips wrote to the NMC case officer asking her to confirm that 'all aspects of Ms Fisher's practice were considered in total when reaching a decision to decline to proceed' and asking for a copy of the specific advice given by the NMC to Clare.

On 17th December 2004 Robyn Phillips telephoned the NMC to ask if the transcripts of the Interim Suspension Hearing and the Investigations Committee Hearing had been destroyed and if not, asked them to ensure that they were kept because HPW 'may have occasion to request them.'

VBAC at home

In June 2005 Clare undertook the care of Jenny Traves, a woman expecting her second baby after a previous caesarean. She went into spontaneous labour and after two hours the baby's heartbeat dropped significantly, with further decelerations. Clare did a vaginal examination and recommended immediate transfer by ambulance, she informed the hospital that she was bringing in a woman with a VBAC labour with fetal bradycardia. The crash team was not awaiting her arrival and instead, after receiving a verbal handover from Clare, Jenny Traves was taken into a side ward to be assessed. The midwives failed to pick up the fetal heartbeat with an abdominal transducer so they broke the waters, which were clear (indicating perhaps that the baby was OK), attached a fetal scalp electrode which recorded the baby's heartbeat for 15 minutes. 20 minutes after admission a doctor arrived, took off the scalp electrode, used a scanning machine and declared that he could not find a heartbeat and ordered a crash caesarean. The baby was stillborn. Jenny shared her story in AIMS Journal Vol: 21 No:1 page 22.

The following morning Jean Keats phoned Clare to inform her that she was conducting an investigation and required the case notes. Clare, meanwhile, was primarily concerned about the health of her client and her client's partner - and attended the hospital every day to support them. During the transfer to hospital Clare had left the case notes in the woman's home - but had provided hospital staff with a full verbal handover. The family returned home - asking for time to grieve. After the funeral Clare collected the case notes and forwarded them to Jean Keats - and these were received by her on June 30th 2009.

HPW had insisted that Jean Keats be appointed as Clare's supervisor, despite Clare's objections, and the principles of supervision require that a named supervisor of midwives should not investigate the practice of 'her' midwife. Nonetheless, Jean Keats was undertaking the investigation. Once more she failed to recognise the conflict of interest – and indeed she also failed to provide Clare with alternative supervisory support until after the conclusion of her investigation, some three months later.

Yet again, Clare was referred to the NMC and the first interim hearing of the NMC was held in January 2006 and adjourned. The next hearing was held in Cardiff in March 2006 and Clare was accused of failing:

1. to provide evidence of continuing professional development.
2. to send a completed set of midwifery records to Jean Keats
3. to keep a contemporaneous record of Jenny Traves' labour
4. to provide hospital staff with Jenny Traves' records
5. to send Jenny Traves' record to Jean Keats.

There were nine further hearings, over 19 days, the last on 1st May 2008. Despite the conflicting evidence, Jean Keats contradictory responses and corroboration of Clare's statements by Jenny Traves, Clare was found guilty of charges 2 and 4 and given a five year caution.

The hearing was a travesty of justice with a panel that was clearly biased against the midwife. In the last two hearings Eunice Foster (due regard midwife) repeatedly fell asleep but the hearing continued despite this matter being raised with the legal assessor who took no action. Clare alerted the Chief Executive's office at the NMC and they took no action either. Jenny Traves, herself a registered nurse, spoke very fluently and effectively in the hearings, her testimonial, however, was disregarded and she was accused of speaking out because of her alleged friendship with Clare, despite having had no contact for a year after the funeral of her baby and only becoming aware of the disciplinary case from reading newspapers.

Val Beale, (Local Supervising Authority Midwifery Officer (LSAMO) South West) the NMC witness presented herself as an expert at home births and skilled at examining case notes; but cross examination by Clare's barrister, Barbara Hewson, revealed that she had little, experience of home birth and was no expert in handwriting analysis. It was Val Beale who contended that Clare may have written the case notes, 'but not these' because they were too comprehensive and too neat, implying that the delay in handing them over was because they were being re-written - despite the mother confirming that she watched Clare write them up. The panel could easily have resolved this by asking Clare to produce three other case files for comparison the next day, they failed to do so.

Following the conclusion of Clare's case Professor Paul Lewis wrote to the NMC expressing his concern about the proceedings:
1. The unsympathetic nature of the panel's approach to Jenny Traves and her partner and the assumption that she was in some way in cahoots with Clare.
2. That the Council's solicitor took a view that was at odds with the advice and information given by the NMC around 'the ownership of records', what a Supervisor of Midwives could ask for and the audit of the PREP standard.
3. That the panel lack the degree of impartiality necessary for the hearing to be judged as fair
4. That the final charges were more about a breakdown in the relationship between Clare and Jean Keats and he seriously questioned Jean Keats' objectivity and ability to continue as an LSAMO.
5. That the panel member who fell asleep (Eunice Foster) and the Chair of the panel (Betty Rush), should be suspended from any further hearings until a review of this case has been carried out by the NMC.

As far as we know there has been no response to this letter from the NMC.

This is a damning indictment of the proceedings by a Professor who is Chair of the NMC's Strategic Conduct and Competence Committee. At the outset of the interim proceedings Professor Lewis had hoped to give evidence on behalf of Clare but the NMC file notes show that they strenuously objected to this on the grounds of the potential adverse publicity that may arise. Instead Professor Mavis Kirkham appeared as a defence witness on behalf of Clare. The NMC did not provide any expert witness independent of HPW's investigation/process.

Complaint to the Ombudsman

On 25th October 2006 Clare made a complaint to the Ombudsman about HPW and their maladministration.

The Ombudsman's report is damning. He found that:
'The investigation undertaken by Jean Keats was not an appropriate investigation for the purposes of NMC Rule 5 and concluded that 'I have identified serious flaws in the investigation and the process conducted by HPW and these flaws amount to maladministration. It is evident that this has caused injustice to Ms F in that she was not given the opportunity to comment on the investigation into her fitness to practise, and explanation put forward on her behalf by way of mitigation was ignored, she was denied any avenue of support during the investigation and at the conclusion of the process she was not notified of her right to appeal the suspension. These failures undoubtedly aggravated what was an already stressful situation. Therefore I uphold her complaint.'

The Ombudsman recommended that Clare receive £5,000 compensation for HIW's maladministration. It is a pittance in view of the number of years she has been victimised and the length of time she spent on suspension without any remuneration. The NMC panel refused to adjourn an additional few days pending the publication of the Ombudsman's report - despite having already taken over two years to deal with these proceedings.

Post-partum haemorrhage

In August 2008 Clare was contacted by Jane Hood. She was 39 weeks pregnant and was very anxious about the forthcoming birth because of the bullying tactics employed by the NHS staff. She determined to find an independent midwife, or give birth on her own.

Clare agreed to care for her and on the 4th September 2008 arrived at Jane's home after being told that Jane was in early labour. Jane had a spontaneous delivery of a baby boy in a pool at home but two hours after the birth she lost around 250mls of blood. An hour later she had a further loss and Clare advised that she transfer to hospital, she refused. Clare spoke with a colleague about using syntometrine (because of the risk associated with raised blood pressure which Jane had normally, but it was fine during the labour) and after discussion administered it. Jane repeatedly refused to move to hospital. At 13.30 Clare spoke with a supervisor of midwives whose only advice was that she should bring Jane into hospital (expecting her to bully Jane into agreeing). Finally, Jane agreed to go in. Clare had her records with her when she gave a full verbal handover to the staff - and she did not see NHS staff making their own records at this point. Jane was then under the care of the hospital staff and Clare had no further input into her care. Their management of Jane was poor, she had a further bleed, and they failed to monitor her properly. There is no evidence that this was investigated.

Two days later Clare received a letter stating that there would be 'an overview' of Jane's emergency admission to Singleton Hospital. Clare repeatedly asked for clarification of precisely what the concerns were but, yet again, she did not receive a reply until the case was referred to the LSAMO - Gillian Harris.

Clare complained to the LSA about Sian Passey's review and the subsequent investigation carried out by Gwyneth Singh (a supervisor of midwives at the Trust). Her complaint was lodged with Gillian Harris on April 2nd 2009 - it has still not been resolved. But when Clare met with Joy Kirby (who was investigating her complaint) on October 7th 2009 and asked whether Sian Passey's review had been on behalf of the hospital or the LSA Joy Kirby - some ten months after the incident that was being investigated - was unable to provide clarification.

Jane Hood had written an open letter stating that she was *'astonished that [the case] is being reviewed without asking me anything about what occurred.'* She was never interviewed and despite her reminder in this letter that she *'requested a copy of my notes in writing on October 1st 2008, and on two further occasions, but have still received nothing.'* [Note: Her initial request resulted in a demand for £35 for the notes, which the Trust cashed in November, but it took a letter to the Information Commissioner before the notes were sent, in February.

In December 2008 Peter Higson, Robyn Phillips, Gillian Harris and Jean Keats met to discuss the 'Supervisory Review' In the space of three months the 'overview' had become a 'Supervisory Review' which Clare still had not had an opportunity to consider and comment upon. They decided that 'advice would be sought from the NMC and a supervisory investigation would be undertaken in the time factor suggested by the NMC.'

Later that month Professor Paul Lewis sent an email to Gwyneth Singh expressing his concern at Healthcare Inspectorate Wales' (HIW) (formerly Health Professions Wales) continued failure properly to follow procedures and engage with Clare stating: *'I would urge that caution is given to ensure that due process is properly followed.'*

On the 29th December 2008 Gillian Harris made a file note of a telephone conversation with Christina McKenzie at the NMC in which she gave the erroneous impression that Clare was not engaging with the supervisory process at all. But Christina wrote in an email to Clare that following discussions with the LSA it was her understanding that there was no LSA investigation underway - yet Gwyneth Singh had been appointed to conduct precisely such a supervisory investigation some eighteen days earlier.

On the 23rd January 2009 Clare finally received a copy of the 'Overview of Care' and noted that she was the only individual named in the whole document, everyone else was referred to by initials.

On the 30th January 2009 Clare met with Gwyneth Singh. She had received the original copy of the 'Overview of Care' - and acknowledged that this was the basis of her investigation, and Maggie Davies (a consultant midwife and supervisor at the same Trust provided Mrs Singh with support). Clare was supported by Professor Paul Lewis, Kay Cotter (her named supervisor of midwives) and Simon Dunn from UNISON. At the meeting Clare was given a copy of Jane Hood's notes to peruse. Clare had been asking for a copy since before Christmas and Jane had been asking for her notes since October 2008 and was still awaiting a copy. Clare still does not have a copy of the notes, despite Jane Hood giving written permission for Clare to have a copy.

During the meeting Clare outlined her actions during the birth, justified her clinical decisions and provided Gwyneth Singh with the relevant documentation.

The report should have been completed within 20 days of the incident. It took over three months, more than six months after the clinical incident that was being 'investigated'. Clare was contacted in writing on 11th December, the other midwives involved were not asked to attend an interview until February - and yet Gwyneth Singh had initially informed Clare that her report must be forwarded by early January, in line with NMC requirements. Jane Hood had written a supportive letter about Clare but she was not interviewed.

On the 23rd March 2009 Gwyneth Singh produced her report and two days later Clare received a letter from Gillian Harris stating that in view of the fact that Clare had a five year caution against her registration she was referring her to the NMC. The NMC then compiled a list of 20 allegations, all of which are hotly disputed.

On the 8th July 2009 an Interim Hearing Panel met to consider whether Clare should be suspended from practice or impose a Conditions of Practice Order. They decided that neither action was appropriate. On the same day there was an Investigations Panel hearing which decided that the case needs *'further solicitors' investigation.'*

On the 2nd April 2009, within the ten day deadline for appeal, Clare wrote to the LSA making a complaint about Gwyneth Singh's investigation. On the 23rd April Clare received a letter stating that Joy Kirby (LSA Midwifery Officer, East of England) had been appointed to investigate her complaints, the results of this investigation are eagerly awaited.

Since then Clare has attended a woman at home and was meant to be supervised. She made repeated phone calls to her supervisor informing her that the woman was in labour but the supervisor did not respond to the calls until the following day, after the woman had successfully given birth. Clare is now being blamed for attended a birth without supervision and yet another investigation has been instigated.

In 15 years as a midwife in Wales Clare has been prevented from working for approximately 4 of those years. In that time there have been nine investigations (three referrals to the NMC, two referrals to the NHS fraud squad, and a recommendation of Supervised Practice (presently under appeal)). The sum total of findings against her are that she did not send her Named Supervisor of Midwives, Jean Keats, a set of client notes (despite offering in writing to meet with her to do so - in a letter that Jean Keats forgot that she received until it was subsequently found archived at HIW); that Clare did not send her patient records for 16 days after a request (despite the fact that they were at the client's house, that the client had post operative complications, and that Clare waited until after the funeral to return them.)

Ironically, the manager, Gillian Harris, whom she reported for bullying and harassment at Carmarthenshire NHS Trust in 1998 subsequently became LSA MO at HPW - at which point Clare's problems at LSA level began. Over that period Clare had no problems when working within the NHS midwifery sector in London, or the nursing sector in general.

A full account of this disgraceful saga can be found at www.aims.org.uk/Clarefisher.

Beverley A Lawrence Beech

Jury of your peers?

Midwifery lecturer *Sarah Davies* reports on the NMC's case against Deborah Purdue

Deborah Purdue: Independent Midwife with 25 years experience - struck off the register by the Nursing and Midwifery Council.

'She is an experienced midwife with good knowledge, skills and competence. She has a totally unblemished record' - the words of the Local Supervising Authority Midwifery Officer (LSAMO) in her report at the conclusion of a supervisory investigation (March 2006) of Deborah Purdue's practice following one birth in July 2005 where the baby, having been born in hospital under medical care, died shortly after birth.

The supervisory report was sent to the Nursing and Midwifery Council (NMC) in May 2006. Debs was not suspended from practice, and continued to work as a midwife, both in hospital and independently, for the next three and $^{3}/_{4}$ years. On 20th March 2009, following a Fitness to Practice hearing, the NMC issued a striking off order - to protect the public.

Midwifery supervision

Supervision is required by British law, and its purpose is *'to protect women and babies by actively promoting a safe standard of midwifery practice.'*[1] Every midwife has a Supervisor of Midwives (SoM) with whom she has an annual review, where her practice is reviewed and any educational needs identified. Supervision of midwives has a very important role to play when there is an adverse outcome; investigating and putting safeguards in place if poor practice is identified; encouraging the midwife to reflect on her care and learn from the experience; supporting the midwife so that she can continue to practice safely and competently, and often, supporting the bereaved parents.

Local supervisory processes in Deborah Purdue's case

Six days after the death of the baby, on 25th July 2005, Debs and the second midwife, her independent midwife partner, were invited to a meeting. This subsequently proved to be, rather than the supportive debriefing meeting that the midwives expected, the first step of evidence-collecting in a supervisory investigation. The NMC[2] (page 5) states *'midwives under investigation […] should be informed about the supervisory investigation before it commences.'* Debs' own SoM wrote a formal complaint on 2nd September pointing out that the process so far had breached the provisions outlined in the Standards and Guidance for Supervisors of Midwives. Her complaint was upheld by the LSAMO, who wrote on 22nd September:

'As you are already aware I share your concerns (…) I will go through the issues with both supervisors - it has certainly made me think about providing specific training around investigation for supervisors in the future.'

The initial meeting having been discounted, a new investigation was instigated, led by a different SoM, who wrote a report on 6th October 2005. There followed three months of emails between Debs and the LSAMO, followed by a meeting on 5th January 2006 to gather further evidence regarding Debs and her partner IM's career history, cases attended and to review previous case notes.

Referral to the NMC

On the 20 March 2006, nine months after the death of the baby, Debs had a meeting with the LSAMO. She was told the LSA investigation was now complete, and that she was being referred to the NMC. In her report to the NMC (sent over two months later) the LSAMO says that she had 'been advised' to refer the case to the NMC. There is no indication in the letter as to the source of the 'advice'. In the letter to Debs informing her of her referral, there are sections of the Midwives Rules[3] quoted under the heading 'Breach of Midwives Rules and Standards' but no specific allegations. The letter concludes with the statement that the LSAMO does not intend to suspend Debs from practice.

one adverse outcome in 25 years

The LSAMO's decision not to suspend Debs at this point indicates that she did not feel that Debs constituted a danger to the public. There had been one adverse outcome in 25 years and in the words of the same LSAMO in the same report to the NMC: *'She is an experienced midwife with good knowledge, skills and competence. She has a totally unblemished record.'*

Referral to the NMC is a serious event, usually related to continuing lack of competence despite supervised practice, where *'over a prolonged period of time a registrant makes continuing errors or demonstrates poor practice'*[3] or because of *'serious professional misconduct.'* The NMC[2] (page 3) cites the most common examples as:

- Physical or verbal abuse
- Theft
- Deliberate failure to deliver adequate care
- Deliberate failure to keep proper records

There were no such issues in Debs' practice.

LSA Guidance, South of England[4] on page 5, section 5 states: *'The NMC will not normally become involved in a case if it is not demonstrated that considerable measures have already been taken to tackle the situation at a workplace level (…) the NMC's role is to protect the public from registrants whose fitness to practice and whose situation cannot be managed locally. (…) Reporting a case of unfitness to practice to the NMC is appropriate to the extent that public protection may be compromised.'*

The question must be asked: why was a midwife with an *'unblemished record'*, and no period of supervised practice, referred to the NMC by the LSAMO in the first place?

Different treatment for independent midwives?

The LSAMO's report continues: *'the situation has been made more complex by the fact that the midwives are independent practitioners. I have grappled with the realisation that if the practitioners were employed within a Trust then they may have been advised to undergo supported or supervised practice and/or disciplinary action.'* The same report, however, recommends that the second midwife in the case, also an independent midwife, *'is placed on a formal programme of supervised practice in accordance with the LSA guidance.'*

The report adds: *'It seems particularly harsh that as a tier of punitive/remedial action is missing (by the very fact that they (sic) are independent) that they (sic) now face referral to the regulatory body.'* (The second midwife organised her own supervised practice and completed it with assistance from the Trust nearest to her home).

The NMC Fitness to Practice process: inefficient and unaccountable

On the 30th May 2006, Debs' case was referred to the NMC. On 24th October 2006, almost five months later, the first investigating committee (IC) met. There were four further ICs held and the NMC heard the case on 3rd to 7th November 2008. Evidence from the initial, discounted meeting was requested - this would be inadmissible in a court of law and so was successfully challenged. Proceedings were subsequently adjourned until March 16th 2009. The panel decided against passing an interim suspension order, justifying its decision with the words : *'Amongst the factors we bear in mind are (1) the amount of time that has elapsed since the allegation and (2) the fact that there is a degree of supervision in place to protect the public.'* Therefore the Council decided in October 2008 that Debs could continue to practice and was not, by implication, a danger to the public. She had been practising as a midwife for the whole course of the investigation, since July 2005, and continued to do so until March 2009, when the Conduct and Competence Committee (CCC) reached its final decision.

The CCC first considered various sanctions:

1) No action: decided against, as *'facts too serious'*
2) Caution: decided against, as *'facts too serious'*
3) Conditions of practice order: decided against, as *'the panel was satisfied that there was no practical method of implementing the sanction'* due to the fact that she was self employed; however, a 'conditions of practice order' had been applied in three earlier cases involving independent midwives.
4) Suspension order: decided against, as *'misconduct was so serious that it was not appropriate or in the public interest to do so.'* Therefore Debs was struck off the register.

Serious misconduct?

Deborah was found guilty of:

1) Failure to carry out proper fetal heart (FH) rate auscultation
2) Failure to conduct an early vaginal examination
3) Allowing 'Patient A' to get into the birthing pool after there had been several readings of the fetal heart rate outside normal parameters.

The CCC panel consisted of: two lay people, a barrister and a retired hospital administrator with no knowledge of midwifery (court transcripts). The other was a midwife, with nine years experience; a labour ward manager in a consultant obstetric unit. Because he was the only panel member with midwifery experience, his opinions went unchallenged. If the NMC hearing had been a court of law, expert witnesses would have pointed out:

In relation to finding 1) The NICE guidelines[5] (the panel's standard for 'proper' FH monitoring) are guidelines not rules. The NICE guideline on timing of auscultation of the FH is not evidence based. There was confusion during the hearing because the guidelines were changed between the incident and the hearing.

In relation to finding 2) Many expert midwives would not conduct an early VE when the labour appeared to be normal. There are other less intrusive ways to assess labour, including maternal observation and abdominal palpation.

In relation to finding 3) *'Allowing "Patient A" to get into the pool'*: the language used gives some indication of the mindset of the panel.

In conclusion:

- The only midwife on the panel came from a hospital background: his perspective is not shared by midwives who have extensive experience of out-of-hospital birth.
- The panel were indeed in a position to impose conditions of practice if they had judged this necessary.
- Debs practised safely for nearly four years during this process. Both the LSAMO and the NMC judged that she was not a danger to the public during this time.

This sad case brings into question the constitution of the NMC and its competence to protect the public. Moreover, the lengthy and inefficient process which culminated in the striking off order, and the consequent stress and suffering inevitably endured by the practitioner, cannot be ethically defensible.

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NCT reveals crucial choice guarantee set to be missed by a mile

Over 95% of women in the UK are not able to choose where to give birth, a new report released today by the NCT (National Childbirth Trust) has found. Offering women choice of where to give birth is government policy across the UK as it is proven to have a positive effect on birth outcomes.

The NCT's report 'Location, location, location' highlights the benefits of choice to parents and calls for governments and health professionals to act quickly to ensure women have these choices available to them.

The 'Location, location, location' results show:

- 95.8% of women do not yet have access to a real choice between the three options of home birth with a midwife, a local midwifery facility (birth centre) either stand-alone or attached to a hospital and an obstetric unit in a hospital (the choices defined in Maternity Matters)[1]
- 89% of women live in areas that realistically do not offer the choice of a home birth with a midwife.[2]
- With greater encouragement of home birth, choice could be offered to many more women without any significant investment or shift in the way maternity services are structured.[3]
- Over 40% of women live in areas without reasonable access to both a birth centre and an obstetric unit in a hospital
- Women are lacking in the information and support needed to make these choices.[3]

The research for the report was commissioned in light of the Government's Maternity Matters[1] promise that all women in England will have access to choice of place of birth by the end of 2009. NCT wanted to ascertain how many women in the UK actually have access to choice. Scotland, Wales and Northern Ireland have also made similar policies that support the provision of choice for women.

Belinda Phipps, Chief Executive, NCT, says:

'There is a huge task ahead for trusts and boards as many are very behind in implementing this policy. For every ten pregnant women, nine are not able to choose where they want to give birth. We know across the UK, government policies support women with this choice. However, in reality this is not even close to being delivered yet.

'We want the governments to act now. Although in a few cases more investment in maternity services will be needed, with a simple re-thinking of the way their maternity services are delivered every trust and board can ensure choice is available to all women.

'We know there are some financial policy obstacles hindering the achievement of choice the NHS could make much faster progress if it corrected these.

'There are a few trusts and boards in the UK that are succeeding in offering women a real choice and these successes are to be celebrated. We now need the rest of the UK to catch up.'

As part of the 'Location, location, location' campaign launched today, the NCT is calling for the commitment to guarantee choice of place of birth by the Department of Health to be implemented fully, and for the governments of Scotland, Wales and Northern Ireland to make a similar commitment to guarantee choice.

NCT is calling for the commitment to guarantee choice of place of birth

To achieve this local and national governments will need to:

- Review the financial framework surrounding maternity services
- Recognise the importance of midwives in reducing costs and delivering choice
- Make sure that women are aware of the options and understand that for healthy women with a low-risk pregnancy, all three options are equally safe places to give birth
- Ensure all in the maternity services work together and have sufficient training so they are experienced and comfortable in all three settings.
- Make sure parents are provided with unbiased information to help them make their choice

Sarah Banks from Derby says:

'The first thing the midwife asked me was "which hospital do you want to go to?" There was no discussion about other options and no mention of the birth centre nearby. I told her that I wanted to have my baby at home and she refused to discuss it as she said it was too early and wouldn't be advisable as it was my first baby.'

Both women and maternity services benefit from choice of place of birth being available. For women it leads to better birth outcomes, increased likelihood of straightforward births and improves their satisfaction with the birth. This in turn leads to higher self esteem and can increase parents' confidence in being able to look after their baby.

For maternity services, offering these choices is likely to lead to reduced costs. Currently most women give birth in an obstetric unit in a hospital which is an expensive option.[3] With greater choice provided for women, more are likely to give birth in a birth centre or at home with a midwife. Therefore the effort necessary to deliver all three options will be outweighed by the savings made through less women giving birth in hospitals.

To find out more about each of the options available to women in the UK and to take action to support the NCT 'Choice of Place of Birth' campaign please visit www.nct.org.uk/choice.

Local Authorities that offer the least choice, % of women of childbearing age who have choice:
Middlesborough 0.0%
Boston 0.0%
Copeland 0.0%
Carlisle 0.0%
Coventry 0.0%

Local Authorities that offer the most choice, % of women of childbearing age who have choice:
South Cambridgeshire 100%
Southwark 100%
Cambridge 100%
Derbyshire Dales 91%
Bath and North East Somerset 91%

A full breakdown of trusts is available at www.nct.org.uk/choice.

'Location, location, location' details access to obstetric units, birth centres and home births in the UK and calculates the rate of women of childbearing age in each area with choice.

1. What is Maternity Matters?

The Department of Health produced Maternity Matters: choice, access and continuity of care in 2007. This guaranteed that women in England would have choice of place of birth by 2009. For more details see www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073312

2. How is choice measured?

There are no Government definitions of what having access to choice means, so to measure access to choice in the UK, NCT used the following parameters:

- Women being within 30 minutes drive of a birth centre
- Women being within 30 minutes drive of an obstetric unit in a hospital
- The area having a 5% rate for home birth. A 5% home birth rate was set as a realistic target should all women be offered home birth as a matter of course. A lower rate would not demonstrate home birth being offered as PCT policy because this could easily be achieved by women who know they want to have a home birth before being offered any options and who, if necessary have fought to be able to have a midwife present at their home birth.

3. What are the barriers to choice of place of birth?

The main factors include:

Staff shortages - in order to retain staff in the obstetric unit and cut costs, trusts or boards may cut back on community midwives, reducing home birth services and closing birth centres. This is an illogical step, as births in an obstetric unit are less likely to be straightforward. This means there will be more pressure on resources such as surgical, pharmaceutical and anaesthetic budgets and the cost of additional recovery time following interventions such as caesarean section.

There are examples of how trusts can make better use of their budget by increasing the number of midwives, introducing caseload midwifery and flexible working hours in the recent King's Fund paper.

Lack of experience and training - the midwife regulatory body expects all midwives to be 'competent to support women to give birth normally in a variety of settings including in the home' in reality, not all midwives are currently trained to be able to attend women giving birth without medical procedures. More training is needed for midwives so they are confident in attending all types of birth

Lack of infrastructure - the main factors limiting choice in the UK are the low home birth rate and a shortage of birth centres. Encouragingly, there are more birth centres planned to be built over the next few years, which will go some way to improving the infrastructure. Unfortunately the financial framework is a strong disincentive to creating new birth centres.

Lack of provision of information - the Towards Better Births report found that only 51% of women who were given choice felt they had sufficient information to be able to choose between the three options. Providing unbiased information on the advantages and disadvantages of each option will help women to make their choice. In many cases women are not aware that there is an alternative to a hospital birth. Once this choice has been made, in order to ensure choice women need to be supported in the option they have selected.

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The NCT (National Childbirth Trust) is the UK's leading charity on pregnancy, birth and parenthood – For more information call NCT on 0300 330 0770 or visit www.nct.org.uk

High-risk home births?

Angela Horn looks at the information available to women

Which is the safest option - home or hospital birth? Expectant mothers (and fathers) wanting to know the facts before they make a choice may be surprised to know that there is little hard and fast information, and much of it is disputed.

Because we can't simply randomly allocate mothers to give birth in one place or another, researchers have to compare what happens to those who choose home birth, with a group of mothers with similar risk factors who choose hospital. And of course, risks can change during pregnancy or during labour, as some women get complications and some do not. However it is not just 'low risk' women who want a home birth. There are many women who say 'never again' after a previous hospital experience and want to stay at home, no matter how high the risks are said to be for them.

Let us look at what the research tells us so far...

In the UK and the Netherlands the evidence continues to accumulate that, for low-risk women, planned home birth compares well with hospital birth. An analysis of over half a million low-risk births in Holland, over 300,000 of them planned home births, found no significant difference in perinatal mortality or severe perinatal morbidity between home and hospital.[1] The UK's Independent Midwives' Association (IMA) data for independent midwife care (largely planned home births) was compared with women under the NHS in Scotland, matched for most risk factors. Various outcomes were better for women and babies under independent midwife care - they were more likely to have a normal birth, an intact perineum, and to establish breastfeeding, and for low-risk cases, there was no significant difference in the perinatal mortality rate.[2] The woman fortunate enough to be low-risk may still not find it easy to have her childbirth decisions supported, but she can, at least, call on published research to back her up.

But what of the woman who is not so fortunate? Does autonomy fly out of the window the moment a high-risk label is stuck on her notes? Symon's paper suggested that, when 'high-risk' cases were included, women booked with an independent midwife were more likely to experience a stillbirth or neonatal death; overall figures were 1.7% perinatal death for the IMA women, compared with 0.6% for the NHS women. When 'high-risk' cases were excluded, there was no significant difference between the two, with low figures of 0.5% and 0.3% respectively. There are echoes here of Bastian's study which found that home births in Australia had a higher overall perinatal mortality rate than planned hospital births, but that a disproportionate number of the deaths were in higher-risk cases:

'At least 18 deaths (36%) ... occurred in twins, post-term and preterm infants, and breech presentations, which would be contraindications for home birth elsewhere. Post-term births had a death rate twice that of other home births, and home birth mortality was 1 in 14 for breech presentation and 1 in 7 for twins.'[3]

There have been some criticisms of data collection in Bastian's study,[4] specifically that it collated outcomes from both licensed and unlicensed midwives, whose training and skills might be variable. It included many births in remote locations where transfer to hospital was difficult even by helicopter. Poor relationships with hospitals could have led to delayed transfer, or hindered communication on arrival. These are additional risks which should not generally apply in the UK, where all midwives are registered and have thorough, nationally recognised training. Nevertheless this study may have useful information if we can separate it from factors less relevant to the UK.

In the USA, Johnson and Daviss looked largely at low-risk women, but noted that:

'Breech and multiple births at home are controversial among home birth practitioners. Among the 80 planned breeches at home there were two deaths and none among the 13 sets of twins.'[5]

There have been criticisms of Symon's comparison of independent midwifery care with NHS care, notably from the accompanying BMJ editorial:

'... the matching process was largely unsuccessful, with numerous important differences remaining, including nutritional status, smoking status, alcohol consumption during pregnancy, geographic location of residence, obstetric risk from previous pregnancy, medical complications during current pregnancy, incidence of breech presentation, differences in preterm birth rates, and incidence of low birth weight.(3) These differences should not be present if the matching process was successful in producing comparable groups. Substantial data gaps, including circumstances regarding transfers of women from home to hospital, leaves discussion about perinatal death hazardously speculative. Further, odds ratios relevant to deaths are implausibly large relative to unadjusted counterparts, with unstable estimates produced because of limited variability in the dependent variable (few perinatal deaths), and should be discounted.'

But rather than attacking the study for its shortcomings, we can consider what it offers. We are not doing anyone any favours if we rush to dismiss research which makes us uncomfortable. As a woman making decisions about her own healthcare, I do not want to feel that people have tried to protect me from things I don't want to hear. Whose interests would be served by that? What I want is not research cherry-picked to support my own prejudices, but good-quality data offered in a non-judgmental way, to inform my own decisions.

That higher-risk births tend to result in higher perinatal mortality rates is no surprise. We would expect them to

have significantly higher mortality than low-risk births in hospital, too. Indeed, Marjorie Tew's analysis of perinatal mortality data from the UK surveys of 1970 and 1985 suggested that, for higher-risk women, consultant care was associated with an increase in mortality.[6] We would expect that obstetric care for women with complicated pregnancies has improved since then. The surprise is that it is difficult to find the information we need to make a fair comparison. So what information would help women with higher-risk pregnancies to choose their place of birth, and birth attendant?

'High-risk' is a broad category and an unhelpful label.

Some studies will label breech, twins, postdates and VBAC births as 'high risk', but the risks involved are different. A risk of needing an urgent caesarean, or of specialised resuscitation, is quite different from a risk of slow progress and unplanned, but non-urgent, caesarean, where there is plenty of time to get to hospital. A mother with one past caesarean has a risk of uterine rupture of roughly 0.35%,[7] but aside from this she is not at significantly higher risk of needing emergency intervention than any other mother. Compare this with a mother expecting a breech baby, who may need a non-urgent caesarean for slow progress, but whose primary concern might be her baby needing resuscitation. We need good-quality data on mortality rates, illness and longer-term outcomes for mother and baby for each risk category; they are different challenges for mother, midwife and obstetrician, so what purpose is served by lumping all 'higher-risk' cases together? If I am expecting twins, I want to know what the stats tell me about twins in the UK, in cases very similar to my own - if twins are fraternal, in separate membranes, full-term and head-down, they are probably as low-risk as twins get, so research including transverse, identical preemies is not really relevant to my decision-making. General 'high-risk' data is no use to any subgroup; those facing a VBAC, breech or twin birth need specific data.

Comparing like with like - different approaches to higher-risk birth

Women who are higher-risk and plan a home birth are, by definition, aiming for a vaginal birth; this may not be a realistic option in hospital. In particular, women expecting a breech baby in an NHS hospital may be given no option other than caesarean section, or at least be strongly dissuaded from attempting vaginal delivery. It is common for there to be no-one confident and competent to assist her. Therefore comparing breech home birth outcomes, for instance, with NHS breech outcomes, may in fact be an amateur way of comparing attempted vaginal birth with planned caesarean section. The Term Breech Trial[8] attempted to do this but left many questions unanswered - for instance it included many births in developing countries and focussed on obstetrically managed breech deliveries.

A comparison of different breech birth outcomes in the UK could give us useful information - but we need to know what is being compared. Symon's paper does not separate out the figures for specific higher-risk birth categories, so we do not know what the mortality rate for breech births was in the IMA cohort. Note that the comparative data for NHS births used by Symon does not attempt to match the planned mode of delivery for any of the babies - the Scottish data is matched for the risk category of 'breech', regardless of whether the babies were delivered by caesarean or vaginally. So we do not know what the comparable NHS perinatal mortality rate is for attempted vaginal breech deliveries. To make an informed choice, we need to know the death and injury rates (and ideally long-term outcomes) for attempted vaginal birth in hospital, and attempted vaginal birth at home. Ideally, we need to know outcomes for midwives with expertise in breech birth, rather than those which include unexpected breeches and inexperienced birth attendants. No such data appears to be available.

Who actually attended the birth?

So does Symon's paper give us a reasonable estimate of the risks of home birth for higher-risk cases? No, because the majority of the stillbirths (10 out of 14) in the IMA group actually occurred in hospital, after transfer. Independent midwives in the UK cannot practice in the majority of hospitals, because of the CNST (Clinical Negligence Scheme for Trusts - a sort of internal NHS insurance scheme) insurance requirements, so the independent midwife is unlikely to have been the lead professional at these births. We can envisage the scenario where, for instance, a woman with an unexpected breech baby transfers to hospital, the delivery is conducted by an obstetrician and the baby dies - but that outcome falls within the IMA data although the delivery was not conducted by a midwife. So the next question is whether these transfers were made at an appropriate time. Perhaps some of them were before the onset of labour - we do know that three of the deaths in the IMA cohort were at planned hospital births. Later transfers may arise from the mother's decisions, or the midwife's judgement. We need this information in order to judge whether mothers and midwives typically had time to transfer once they had decided it was necessary, in higher-risk home births.

It's not just death that matters.

Death and serious injury are important measures of risk, but they are not the only ones on which we base our decisions. We also need to know about the long-term physical and mental health of mother and baby. Birth experience may impact on establishment of breastfeeding, with long-term significance for the health of both baby and mother. And while death and serious injury are, mercifully, unusual in even higher-risk births, less spectacular forms of harm are more common. The full consequences of different approaches to birth may not reveal themselves until long after a woman's childbearing career has ended. There is evidence that caesarean section increases the risk of infertility, and of mortality and morbidity in subsequent pregnancies.[9] It may also increase the chances of asthma in children.[10] We will probably never know all the questions that we should ask, let alone have all the answers - but we deserve better

than studies which only look at a mother's and baby's physical health for a few weeks after the birth. We might also benefit from a little humility, in accepting that long-run effects of childbirth on a woman's mind and body can be hard to ascertain, and that if the 'experts' cannot be sure how each option will affect her in the long term, then what right do they have to limit her choices?

The Subjectivity of Choice

Whether consciously or otherwise, we have to weigh the likelihood of various outcomes against their cost, or benefit, to us as individuals and families. It can be rational for individuals to make different choices in similar situations, depending on the priority each person places on different outcomes. And here we come to the crucial issue for autonomy in childbirth. If a woman is hospital-phobic, the 'cost' of hospital birth is far higher than for the woman who feels that hospital is a safe place. How can we quantify the long-term damage which might be done to her by denying her the support to give birth where she feels safest? Some women's antipathy to hospitals is so strong that they refuse to attend under any circumstances, regardless of their midwife's advice; in law, a woman is entitled to make that choice, as AIMS has explained on many occasions. Symon notes that if independent midwives were not available, some women might choose unattended childbirth instead - raising the possibility, he says, of worse clinical outcomes.

And it's not just about 'feelings'. Consider a single mother expecting a breech baby, with other children at home and no help. She may have to carry a buggy up several flights of steps daily. For her, the 'cost' of an elective caesarean will be higher than for a woman who can convalesce with support at home.

Reluctant home birth?

For some women, home is the first choice for birth, and nothing a hospital or birth centre could offer is relevant. Unless there is a medical need, they will not consider birth away from home. For others, planning a home birth is a reluctant decision driven by the lack of alternatives. This is particularly so for women with higher-risk pregnancies, who find that NHS care is often fragmented, and inflexible.

Fragmented care versus continuity

Fragmented care can only add to the risks of a woman who already has complications in her pregnancy. TAMBA's report into the antenatal experiences of mothers of twins[11] gives examples:

A lack of continuity in antenatal care is commonly expressed by mothers in the survey, some of whom saw a different health professional at each appointment:

'Consultant care was very poor - we had to insist on seeing the same consultant towards the end of pregnancy as we were being given totally conflicting advice when we were seeing different consultants...'

'I kept getting lost in the system, was refused appointments I was asked by my consultant to make. No one booked me in for a C-section even though both my twins were transverse at 36 weeks. No one seemed to care, consultant wasn't interested and I never had a midwife. I was also refused blood tests for my underactive thyroid which was supposed to be checked regularly while I was pregnant; it was only done once when I demanded it.'

In contrast, women accessing one-to-one caseload midwifery care, whether independent or on the NHS, can be sure that one professional knows their background and will take responsibility for their care. Currently this is rare on the NHS, outside small midwifery teams such as the Albany. Independent midwives can provide continuity outside of hospital, but higher-risk women, more than anybody, need their midwives to be able to accompany them on transfer, and to work with hospital staff, to ensure that nothing is overlooked and their history is taken into account by every caregiver. Some NHS community midwives have also complained that their hospital colleagues do not take their concerns seriously, which can make it difficult to support a safe transfer.

Inflexible, impersonal

Higher-risk women may be told that their only option is an elective caesarean for twins or breech presentation. If they insist on attempting a vaginal delivery, they may only be offered rigid protocols specifying lithotomy position for delivery, epidural, continuous electronic fetal monitoring restricting mobility, etc. These interventions may not be evidence-based; even if there is evidence suggesting they reduce mortality levels, they may not be appropriate for every situation, and women may decide that the costs outweigh the likely benefits in their case.

Let's consider twin birth. The jury is still out on the method of delivering twins which produces the lowest perinatal mortality rate,[12] but we must not lose sight of individual safety in pursuit of statistical safety. If elective caesarean turned out to have a lower death rate overall, that would not mean it produced the best outcome in every twin birth. We might consider how many caesareans were necessary to prevent one birth complication, and make a judgement in each individual case whether the risks were worth it. Similarly, there is conflicting research on whether perinatal mortality is lower if twins are delivered electively at 37-38 weeks, or left to await spontaneous labour.[13] But suppose it were true that, on average, twins had a lower death rate if born by 38 weeks - this would not mean that every set of twins will be safer if born by this gestation. We have to look at the range of possible outcomes for individuals, not just the averages across large groups. Justine Caines of Homebirth Australia[14] comments on what the hospital package offered when she was expecting twins:

'Very few women would knowingly put their baby or themselves at risk. Why then are women with "special needs" granted less insight or knowledge of their body's capacity or their baby's wellbeing?

'At 38 weeks my babies would be smaller and more likely to need additional care. In the event of a caesarean section I would need to recover from major surgery and at the same time attempt to breastfeed two babies and care for another four children. This was considered a safe option?

'How could my babies be safer with a routine induction at 38 weeks, when they were more likely to need resuscitation and medical care? How would constant foetal monitoring assist when studies have shown its routine use has seen no improvement in outcomes only an increase in caesarean section? How would my babies or I be safer with an epidural that would prevent me being upright, the proven best physiological position for normal birth? How would I be safer being denied deep water for pain relief?

Justine chose instead a midwife-attended home water birth:

'Both babies were born with APGARs of 9 and 9. I had a slight graze. I had a physiological 3rd stage, birthing a vary large and healthy placenta 45 minutes later. I had minimal blood loss and recovered beautifully. Our babies' entrance into the world was sacred and safe. In comparison they could have been cut or pulled from me before they were ready, most likely with worse results. The irony is that the latter choice is seen to be "safer".'

Justine's family achieved the best-case scenario, of mother and babies in excellent condition. We know that midwifery care, and home birth, increases the chances of a normal birth. Higher-risk women should have the chance to aim for the 'gold standard' of a physiological birth - but in hospital, many can only labour under conditions which make it extremely unlikely. Inflexibility in hospital care for women with higher-risk pregnancies may drive them to plan a home birth as the only way to attempt a normal birth.

Women of all risk levels often comment that a previous bad experience in hospital led them to plan a home birth. While they may agree that obstetric interventions were appropriate, care was impersonal; they complain that they were not listened to, not treated with respect, and not consulted:

'...I felt bullied, dismissed, isolated, frightened and lacking in control. Information was not provided, no thought was given to my emotional wellbeing and the people I love (who could have taken care of me) were kept away except for "visiting hours".'

Critics may dismiss such concerns, but clearly there is a problem to address if women are choosing home birth because they are scared of how they may be treated in hospital, rather than because they believe home is the most appropriate place for them to give birth.

Before CNST effectively stopped independent midwives practising in NHS hospitals, an IM told me that she didn't need to do high-risk home births, because her clients could have an undisturbed birth in hospital. A respectful relationship with the local maternity unit allowed her to use her expertise in attending breech and twin births there, knowing that access to emergency caesarean section and the neonatal resuscitation team was minutes away. Her clients had true choice. In some units NHS midwives have the autonomy and professional support to practise in this way; why not more? Women who employ independent midwives often comment that they paid to keep the NHS off their backs, to have their right to decline certain forms of care respected. Should we really have to pay to have people listen when we say 'No', to receive true midwifery care, regardless of risk level?

We have to be honest about the risks, and then allow women to make their own decisions. We know that in theory we do not lose any rights by going into hospital, that we can still decline interventions - but women who have been there and tried to do that, report that it is not that easy. A woman who feels that her baby stands little chance of a gentle birth in hospital, may choose home birth reluctantly. I wonder how many higher-risk women in these studies felt this was the only way they, and their babies, would be treated as individuals?

Angela Horn
www.homebirth.org.uk

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Confident Women Experience Better Childbirth

An independent conference for professionals 7 November 2009

A move by mothers towards 'normal' childbirth and the prevention of unnecessary and expensive medical intervention was the subject of an well-attended independent conference for professionals.

The central theme was the importance of encouraging women and midwives to (once again) believe in the ability of mothers to give birth as naturally as possible. Medically-assisted births are said to have reached 'crisis' levels and now account for more than a third of all births in England as well as being a strain on the public purse.

The NHS tried to reverse the trend by publishing a toolkit, 'Pathways to Success', in 2006, focused on reducing caesarean births but the overall figures have not changed. In England almost a quarter of all births are by caesarean section. Then there are non-surgical medically assisted births (delivery by ventouse or forceps) giving a total of 36.8%. In Scotland 38.7% of births are medically assisted and in Wales the figure is even higher at 50.7%.[1] There are no published figures for Northern Ireland.

Women are now demanding normal births as shown by the growth in use of a hired helper called a doula, after the Greek for slave. The doula is around before, during and after the birth lending comfort, non-clinical help and encouragement to the mother alongside the midwife. Last year 2,500 women employed a doula whereas just 700 were employed in 2004 the conference heard. Celebrity endorsement was given last year by actress Nicole Kidman who chose to have a doula at the birth of her daughter.

Kent MP Paul Clark (Gillingham and Rainham) whose special interest is health matters, opened *'Childbirth: Belief in Action'* at Canterbury Christ Church University, to a targeted audience of midwives and midwifery students. It is the second in a series of campaigning conferences organised by Sue Stephens, a highly qualified midwife who now works as a doula. Its agenda: to inform both students and midwives about the latest thinking on childbirth.

'Medical intervention has reached crisis levels and mothers are beginning to take matters into their own hands. I believe passionately that we need to rediscover 'normal' childbirth,' said Sue.

Leading authorities on childbirth spoke and gave workshops on subjects ranging from vaginal examination to legal matters. Campaigning independent midwife, Mary Cronk, MBE, gave a workshop on breech birth based on some 40 years experience and 1600 births.

Excerpts from two American films were shown by Patrick Houser of Fathers-To-Be: 'Orgasmic Birth,' which extols the potential mental and physical benefits of childbirth, and another showing the final moments of the first-ever American water-birth many years ago. (Patrick's second child.)

Professor Lesley Page, editor and contributor of 'The New Midwifery' gave an account of 'Keeping Birth Normal' and the day closed with debate at Question Time.

'When belief is coupled with suitable environment and good support, mothers view birth as a positive experience,' says Sue.

'On the other hand, high-tech maternity units providing over-medicalised, expensive and unsupportive care can lead to unnecessary mental and physical trauma for the mother,' she adds.

Speakers were:

Prof. Lesley Page, Dianne Garland, Mary Cronk, MBE; Mary Stewart, Patrick Houser, Sarah Gregson, Andrew Andrews

Carolyn Woodward

A DVD/and pictures of the conference are available upon request from woodwardpr@fsmail.net

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Safer Birth

The King's Fund in 2008 reported that an estimated 62,746 safety 'incidents' were recorded in English maternity units between June 2006 and May 2007, with moderate harm in 11% (6,902) of cases; severe harm in 1.5% (941) of cases and death in 0.5% (314) of cases.

Why?

By Ameena

I want to know why. When I came to your hospital for help and relayed my fears I was reassured. I want to know why. When I was at my most vulnerable and relied on your doctors, their actions were not in my best interest. Why? I want to know why women these days must learn to double check any information received from a supposedly reputable source within these walls. Why? I trusted your hospital and I trusted your doctors and at the moment I needed them most I was let down.

Why? When my labour was induced I was told it would take a few days.

Why was I restricted to the bed?

Why was I denied food several times?

Why was my privacy violated when someone opened the door to the bathroom while I was in it without knocking. There was no lock on the door.

After 16 hours of little progress my water was broken. Not with an 'amni-hook' but with something that resembled a flat wooden stick. It felt a lot worse than your average vaginal exam.

I want to know why I never saw the same doctor.

I want to know why I was offered an epidural as soon as my waters broke when I was 1cm dilated without being consulted about the risks involved.

I want to know why I wasn't told that epidurals increase the need for further intervention, can make breastfeeding harder in the first few days and have the potential to stall labour.

I want to know why syntocinon was prescribed without first checking to see if my labour contractions were regular.

I want to know why no one told me that being on syntocinon for long periods of time has the potential to cancel out the effects of the epidural at the worse possible time - which it did.

I want to know why I wasn't told that syntocinon makes the contractions hurt more and harder to deal with.

When I asked you about the nurses you said they were midwives and very nice. Why did I hear one of your nice 'sisters' yelling at a woman crying in pain from labour. Why did she tell her to shut up and that labour was supposed to be painful?

Why was my nurse absent from the room when I needed her?

Why was I left alone and scared?

Why couldn't anyone reassure me and tell me I'm doing well, and that I can do it?

Why was I scared into having a Caesarean section at my most vulnerable time?

Why was I told my baby would be big when she was only 8 pounds?

Why does your hospital employ anaesthetists with different levels of skill?

Why couldn't one of your anaesthetists administer a spinal when the one on the previous shift had no problem giving me an epidural.

Why was I sitting in theatre for 30 minutes crying my eyes out while you poked and prodded in my back?

Why was the room full of people, everyone watching me and no one reaching out a hand to calm me or console me?

When you put me under, and woke me up I was in a strange place without my baby, why?

Why couldn't I breastfeed my baby? Why wouldn't she latch on?

Why do I still feel scared and violated?

When I asked for help why was no one trained in how to teach a woman to breastfeed?

Why did I skip my post partum check up?

Why am I the one who feels embarrassed?

Where is the compassion within your staff? Why did they become health care professionals if not to help others?

Why did they take that notorious oath?

Why is physical well being more important than mental? Why can't they see how intertwined these two become during the process of labour?

Why can't I sleep at night?

Why do I feel that although its been eight months, this happened only yesterday?

Why do I still feel scared and violated?

Why do I feel like I can't make a difference?

Why?

Ameena

A big thank you

Jennifer Mountain shares how she got supportive care for her home birth

I bought the NCT Home Birth book by Nicky Wesson which recommended your website. It was my first child and the BirthChoiceUK website showed Northumberland as having the lowest rates of home births for any county.

From day one I knew I wanted a home birth because I felt it was the most relaxing place to birth my baby naturally without hospital intervention. I'm no lover of hospitals and knew if I had to give birth there tension would slow my labour down necessitating pain relief and intervention. I wanted a positive experience!

My midwife was against the idea of a home birth and made disparaging comments throughout the first thirty weeks of my pregnancy. She claimed I had a water infection and anaemia at every appointment, even though urine and blood tests did not back this up.

Finally, at thirty one weeks, my partner and I had to sign a 'Home Birth Assessment Form' in which the midwife had written down many reasons why I couldn't have a home birth. First she claimed, at the examination prior to signing the form, that the baby was suddenly breech when it had always been cephalic and I'd not felt any huge turning movements. I'd had a scan at twenty eight weeks which showed the baby was in a head down position. It also suggested that the baby was one and a half centimetres smaller than it should be and if that became three then no home birth.

Then my midwife again wrote that I had a urine infection and anaemia (I had been drinking gallons of water and eating iron rich foods alongside vitamin C). My midwife also wrote that there were four others booked for home births that month and it would be first come first served if two of us went into labour at the same time. My midwife said I couldn't have a home birth if there was bad weather, at which my partner exclaimed, 'In May?' We were told it may be foggy and one midwife lived in Gateshead. There is a dual carriageway from Gateshead to where I live.

Adrian, Jennie and Irwin

Basically there were excuses after excuses. I had tried all along to be calm and business-like with my midwife as I'd read that lack of training or experience could be making her nervous about a home birth, but she had been blunt and tactless with me throughout the appointments I'd had and in this final one she called me Judith (not my name) about six or seven times before getting frustrated with herself. When would we cave in and agree to a hospital birth? Ironically all the staff I'd met at the hospital for the scans I'd had were fantastic, positive, helpful professionals.

excuses after excuses

When I left the appointment with my midwife I saw someone from my antenatal class and before even before saying hello she asked, 'What sort of mood is ****** in?' I knew then I had to write to the Supervisor of Midwives to get a change of midwife.

Although it took a month I was relieved to be seen by a different midwife from another surgery. She went through the Home Birth Assessment Form again, explaining when I'd need to collect the bag from the hospital, when they'd deliver the gas and air etc. She talked like the home birth was a reality. She said very honestly said that a home birth can have the midwives buzzing for days if it goes well, or if it doesn't it's the worst place to be. She then confirmed I hadn't got a water infection or anaemia and on examination said the baby was still in a cephalic position.

My baby boy was born 11 days early at 6lbs 10oz which was totally manageable. My waters went without any warning at 10pm and contractions were three minutes apart straight away. When the midwife arrived twenty minutes later she said I was fully dilated and ready to push! I didn't have time for the water birth I'd planned and didn't use any pain relief. At 1am my baby was born. It was a positive experience!

I am unsure what to do about the midwife who was so lacking in confidence about a home birth (not to mention dishonest in making false entries into my notes to support her attempts to get me into hospital). Writing to the Chief Executive at the hospital may perhaps help prevent another women being duped into a hospital birth as he and the Director of Midwifery may be completely unaware of this midwife's behaviour and it would be helpful to alert them to it. However, I'm not sure if I will. Like most women I don't want to rock the boat ... though I will email the 'have your say' investigation for the NHS at www.cnm.independant.gov.uk.

I am astounded how intimidated women are of midwives and how I was. Nearly every woman I speak to be it family, friends or acquaintances at ante and post natal groups, they all have had a negative experience at some point with one of their pregnancies. These days you don't necessarily see the same midwife throughout your pregnancy and rarely does your community midwife deliver your baby but still there seems to be no one with a perfectly positive experience.

Perhaps that's not possible, even as far back as my 86 year-old Gran's babies' births (she had one hospital birth and three home births) there are tales of woe.

The midwife I originally had obviously was not popular and considered moody by other mums to be but when I sent my letter to the Supervisor of Midwives she seemed totally surprised that one of her midwives was not toeing the line and said in writing 'all of the midwives support women's choice to have a home birth.' The reality is somewhat different. She also said if that midwife was on call when I went into labour she would still have to attend albeit as the second midwife who looks after the baby. I had already said in my letter that I was concerned that this midwife would impede my labour by making me anxious so I had to write again reiterating my desire not to be attended by that midwife. Had she have been sent I would of asked her to leave the room if I had felt under pressure in her presence. She had made me totally worried and miserable during my pregnancy. I only wish I'd had the courage to write to the Supervisor earlier but as I've said, women seem to be afraid of midwives.

I need to say a big thank you to AIMS for the information and for the draft letters on the website, it made a big difference to the care I was able to get.

Jennifer Mountain

Stop Press

Albany Midwives Axed

King's College Hospital has abruptly severed its contract with the Albany Midwifery Practice (AMP) with no prior consultation with the women - and without proper provision in place to replace the service - leaving expectant and new mothers in the lurch and anxious about receiving appropriate care.

King's has claimed that it has suspended the service because it has the safety of the mothers and babies at heart. They selected a number of Albany cases admitted to their Special Care Baby Unit and asked the Centre for Maternal and Child Enquiries (CMACE) to investigate.

Peckham ranks as the fourteenth most deprived district of 354 districts in England. The Albany midwives have a perinatal mortality rate of 4.9 per 1000 in comparison with 11.4 for the Southwark area, a caesarean section rate of 14.4% compared with 24.1% at King's and a breastfeeding rate of 80% at 28 days compared with 35% at 7 days.

The AMP offers a Gold Standard of Care to around 200 women in Peckham each year, many of whom are from deeply disadvantaged backgrounds. It provides an outstanding service which enables women to be cared for by a midwife they know throughout labour, over 40% birthing at home. It is unacceptable to withdraw such a safe and much needed service from the poorest women in society.

'I feel blessed and truly privileged to have had the Albany midwives care for me during my pregnancy. They are an amazing group who go out of their way to treat their women (and our families) with the care and consideration we deserve during our pregnancies. I know for a fact that I wouldn't have had the confidence to resist an instrumental delivery if I had not been so well informed and supported during my pregnancy and labour. I also know that I wouldn't be the confident mother I am today if I had not met the Albany midwives. They have made a profound impact on my life and if I am blessed with a further pregnancy I wouldn't hesitate in trusting them again with my care.'

Serra

King's looked at a selected number of Albany cases admitted to their Special Care Baby Unit and asked the Centre for Maternal and Child Enquiries (CMACE) to investigate. They excluded babies from the King's unit and we do not have other crucial data - comparative rates of mental illness after childbirth, where we believe the Albany is likely to have far better results. Professor Alison Macfarlane, a healthcare statistician at City University, commented: *'The study methodology employed does not lend itself to a meaningful statistical analysis.'*

The AMP has long been acknowledged as a centre of excellence, yet King's management is unwilling to provide this standard of care for more women, and instead is trying to remove it so that women have no choice but to accept medicalised care and increased risk.

AIMS is demanding that King's College Hospital releases the CMACE Report and the comparable statistics for its own consultant unit so that data from both services can be examined objectively.

Join the protest and for further information go to:
www.savethealbany.org.uk

AlbanyMums on Facebook:
www.gopetition.co.uk/online/32641.html

Reviews

Touching Distance

by Rebecca Abrams

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I have enormous respect for Alexander Gordon. His single work, A Treatise on the Epidemic Puerperal Fever of Aberdeen was published in 1795, soon after Joseph Clarke, Master of the Rotunda Hospital in Dublin, had struggled with his third epidemic there. Clarke, who described the fever as 'treacherous', watched helplessly as it scythed down the lives of dozens of women, despite his most diligent efforts at whitewashing the walls and floors of the affected wards in the hospital's attic storey and throwing open the windows, attempting to treat the fever, all the while keeping scrupulous notes as to the condition of each woman who contracted the fever. Distressed and puzzled by its seemingly vicarious pattern, one ward remaining entirely unaffected, Clarke wrote that the 'partial distribution of disease rendered it probable that this fever derived its origin from local contagion, and not from anything noxious in the atmosphere' (Clarke, 1849).

Puerperal fever was strongly associated with the large lying-in hospitals

It was Gordon, quite outside the great system of lying-in hospitals in European cities that would lead to the dominance of the emerging medical specialism of obstetric science, who made sense of that observation on 'local contagion'. The Treatise is a punctilious account of the sudden appearance of puerperal or childbed fever in Aberdeen, killing a woman first in December, 1789, the epidemic continuing to March, 1792 when it had spent its force.

Puerperal fever was strongly associated with the large lying-in hospitals of European cities and thus Clarke had the dubious advantage of keeping an extensive registry on hundreds of women. There was no lying-in ward in Aberdeen and the nearest hospital was in Edinburgh (also stricken with epidemic fever: in 1750, all the women who contracted it died). There was a dispensary system which provided the services of a physician to visit poor families and there were local nurses and midwives who assisted women at the time of labour and birth. In a small city, Gordon had a much more limited number of women to observe.

Yet as Rebecca Abrams makes clear in her absorbing fictional account, Touching Distance, of how Gordon came to understand the cause of this puzzling and terrible affliction, practising within the community felt almost more claustrophobic than the delimited but remote space of a lying-in hospital. In the community, local feelings about who was a 'safe pair of hands' for the woman approaching her labour, and who not, ran to fever pitch during the extent of the epidemic. Abrams does not use the precise order of the names and the dates of the women brought to bed and their subsequent illness and death from the fever that Gordon records with such care, as he tries to comprehend the information to hand on each woman, to make it yield up patterns, hypotheses, answers, proof. Instead, she transforms them into a much shorter timeframe to evoke a compelling story of the suffering and dread for the woman and her family members and neighbours that accompanied the epidemic. Especially well captured is the fear men experienced as their wives lay dying and all about were powerless to prevent this happening. The turmoil and struggle this initiated in Gordon himself is wonderfully portrayed and enabled me to envisage better what lies behind the intensity that his Treatise conveys.

As Clarke suspected, puerperal fever was a 'local contagion'. Gordon's Treatise proved this and laid out who would be affected by this contagion and who not. Gordon wrote:

'this disease seized such women only, as were visited, or delivered, by a practitioner, or taken care of by a nurse, who had previously attended patients affected with the disease.'(1795: 36)

Lamentably, his proof and his careful steps to prevent transmission, especially burning the clothes of the woman who had given birth and those of the physician or midwife attending as well, lay ignored by the big obstetric names of the day for many, many decades. Whereas women died in their ones and twos from puerperal infections in isolated rural communities where traditional midwifery had less scope to transmit infection, they died by the scores in lying-in hospitals up to the early twentieth century where doctors themselves made birth unsafe. The findings of Semmelweis and Oliver Wendell Holmes from the mid-nineteenth century suffered the same fate as Gordon's work. The difference is that Gordon wrote his Treatise not only earliest but outwith the prestigious centres of obstetric medicine.

The Treatise is an example of good science, relying not on the conventions of the day, of how things have been or are done, observed and recorded, but reflecting on what needs to be construed as evidence in order to achieve sounder explanations. It brings to mind what the

scientist Evelyn Fox Keller (1992) has written, that the work of systematically identifying information in the broadest sense, using a consistent methodology to build reliable explanations, is above all a 'social' task, that needs attention paid to the social and cultural norms of how science works, how it sees and what it does not see. Gordon's work makes me remember how good science demands genuine boundaries, which has not by any means been commonplace in relation to arguments about childbirth, as we know too well.

Abrams has handled skillfully the difficult 18th century medical language about the female body, so that we come to understand the diagnostic trail whereby Gordon reaches his conclusions. The one major drawback is that Gordon's story is presented as an example of Enlightenment progress. Thus Abrams brings in a conventional story line of the majority of the untrained or less well-trained local midwives, the 'howdies', in the contemporary dialect of the period, who treat birth and the threat of puerperal fever very differently and who react badly to Gordon's approaches. While it is true that midwives were excoriated in the writings of most 18th medics, I think it wise not to take this conflict at face value as a gendered struggle between backward-looking superstitious women and forward-looking men (and, one woman, in Abrams' account) of science. The evidence of the standard of midwifery in the early modern period is mixed on both sides of the gender divide. As ever, excellent tutelage of midwives in the making seemed to be crucial, so we have the seventeenth century Louise Bourgeois at the Hôtel-Dieu in Paris and the eighteenth century midwives, Elizabeth Nihell in London and Martha Ballard in New England, upholding far higher standards than their male counterparts in the surgical and medical professions, alongside countless unnamed peasant midwives who had good observational and other skills to support birth. However, Laura Gowing's work on the role of older married women and midwives in seventeenth-century England imposing restrictive and invasive control on young women who are entering into marriage and childbearing, often to their physical detriment, is not just the work of backward 'howdies': it is women maintaining that tight social order on behalf of a firmly entrenched male hierarchy. We might identify a theme that has resonance in contemporary accounts of what we must term obstetric nursing.

I am not a critical reader of fiction, so as to the novel itself and the way Abrams deals with the subplots of Gordon's life, I cannot comment, except to say that her research has been extensive. There is one sentence in the Treatise's Preface that gives a clue as to how Abrams has developed the novel. Gordon is speaking of what he considers his grave responsibility in 'laying before the public' his observations about puerperal fever and apologises for not discharging his duty sooner, the epidemic having ended in 1792, three years before the Treatise is published. Gordon writes:

'The delay was occasioned, partly by the laborious duties of my public office, but especially, by a complication of domestic calamities'

The sub-plots leave a powerful sense of 18th century Aberdeen physically and socially, at a time when its position as a port town allowed full engagement with the expanding imperial empire. This included the vexed issues of slavery, indentureship and child labour which were intrinsic to the success of that empire.

If the novel encourages any of you to want to get hold of Gordon's Treatise, a search through the historical archives of Royal College of Surgeons, Edinburgh, or any of the three principal deposit libraries in England will yield a copy and a fascinating afternoon's reading. It will also contribute to an understanding of how intuition and hunches have a crucial role to play in moving towards best evidence.

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Exploring the Dirty Side of Women's Health

edited by Mavis Kirkham

Routledge 2006
ISBN-10: 0415383250
ISBN-13: 978-0415383257
£24.99

This book is mainly a collection of conference papers, (from Pollution and safety: exploring the 'dirty' side of women's health, Sheffield 2004.)

It is aimed at health professionals and students rather than mothers but does contain some ideas and discussion that could help all of us to understand some of the complexities of attitudes to women and their health. It also sheds light on relationships and power differentials between professionals, which are partially based on who does the 'dirty work'. In her introduction Mavis Kirkham states that 'Women leak, inevitably and often bountifully. Menstrual blood, birth fluids, breast milk and sometimes tears…' She goes on to say that 'Dirt is defined by Mary Douglas as "matter out of place."' The anthropologist, Mary Douglas's classic work is referred to by several of the authors to question what constitutes dirt and to draw attention to the fact that you can't answer that question without considering context. We are constructed by our particular culture and that determines how we feel about our bodies, what comes from our bodies and how polluting to others that may be.

We are constructed by our particular culture and that determines how we feel about our bodies

The book is divided into four sections, the first is titled Mothers, midwives and dirt - past and present. The opening paper is Birth Dirt by Helen Callaghan, in which she distinguishes between 'sick dirt' and 'birth dirt' but shows how each is open to interpretation and will vary according to the time the place and the culture. The term 'birth dirt' was coined to describe the theory which explains the power and/or dirt relations in childbirth, for example there are many differences in how people both feel about and deal with the placenta. One statement she makes did make me sit up and I'll quote it at length, *'During labour the woman's reproductive passages but particularly the genitalia are a primary focus of the health professionals' attention or gaze. This is a cause of embarrassment for some women … the need of the labouring woman for modesty and privacy during labour is sometimes forgotten by health professionals in modern Australia ... examinations … can be a source of distress, discomfort and embarrassment for some women...'* This struck me as massive under-statement! I did feel when reading this that the lay person might well have expressed this very differently. I suspect that part of the journey towards becoming a health professional means cutting yourself off from the normal reactions of shame and modesty, reactions that as a 'patient' we learn to hold back and inhibit. For myself and women I know the concepts of dirt and contamination are very different in a public place attended by strangers and at home with intimate others.

Rachel Newell's historical study examines the end of the post-partum period as marked by the Anglican rite of the churching of women and links it with the modern postnatal examination: giving a 'clean bill of health'. She goes on to discuss 'ritual purification' or cleansing in the health care system. I think many women in Britain today would think of a cleansing ritual as something very alien but it is something that has until relatively recently been a part of our culture and perhaps lingers on.

Breast feeding as pollution, the second section, addresses the dilemmas and contradictions of breastfeeding in societies where the official rhetoric is at odds with the media-encouraged view of breasts as primarily sexual: consequently explaining women's difficulties in breast-feeding in the very public space which is the modern postnatal ward, and their use of flimsy curtains to give themselves some privacy. There is discussion of the historical antecedents to our present situation: the industrial revolution leading to the scientific discourse around infant feeding at the beginning of the twentieth century portraying breast milk as dirty and contaminating and formula as clean and scientific.

Section 3, The Dais, examines the complexities of dirt and pollution in India and Pakistan where birth for many women is at home attended by family and an untrained traditional birth attendant, the dai. Dais are usually poor, illiterate low-caste women who could be skilled birth practioners but who may be made scapegoats for maternal mortality and morbidity and blamed for the effects of other macro-level processes. They do the 'dirty' work of birth. Section 4, Leakage and labelling, looks at such areas as gynaecology nursing, female urinary incontinence and sexually transmitted infections.

I have often wondered about some of the important questions that are raised in this book. Unfortunately there are no easy answers. This book does offer a few clues as to how an understanding of how societies deal with the 'dirty' side of women's health might tell us a lot about how women as a whole are seen and explain something about the status of women health workers particularly midwives.

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Normal Childbirth: Evidence and Debate

Edited by Soo Downe
Churchill Livingstone, 2008
ISBN-10: 0443069433
ISBN-13: 978-0443069437
£25.99

This is a tough book in several ways. It was first published in 2004 and now in a revised edition in 2008 it addresses probably the most crucial question in our understanding of how women give birth: what does normal, physiological birth look and feel like?

There is plenty of debate on this question and I think anyone with an interest knows that the generally accepted view of what is 'normal' now includes interventions which are patently not normal although they may be common or indeed usual: induction and acceleration of labour; ARM; episiotomy and epidural analgesia all are examples of this. But these essays add up to a powerful argument that, despite what we have observed as a radicalisation of ideas within Britain over the last 20 years reflected in government policy and a belief generally in the ability of women to give birth without intervention, what is happening is a 'normalisation' of a medical model in this country and worryingly in the rest of the world too. AIMS Journal Vol:20 No:2 2008 painted a sombre picture of childbirth practices in Europe and a future issue will examine how the rest of the world may be influenced to adopt Western practices.

In the first section, Ways of Seeing, Soo Downe and Christine McCourt tackle the difficulty of applying a research model based on 19th century science. They argue that although this is well suited to evaluating the efficacy of drug A as opposed to drug B this model is not so well equipped to tease out the complexities involved in normal physiological childbirth including the crucial social, psychological and spiritual aspects. These aspects are not optional 'add-ons' either for women and their families, or for their midwives. So while we are relieved to see NICE collecting together research evidence so that our heath service can benefit both practically and, of course, economically from the best evidence available, we must also contemplate the limitations of the evidence that we have.

The gold standard of the randomised controlled trial, (RCT), has not helped us with such important and basic questions as the relative safety of hospital birth compared with home birth for women without complications of pregnancy. The NICE Intrapartum Guidelines might be useful in many ways but can't address this central question satisfactorily because the research doesn't really exist. There are no RCTs on home birth versus hospital birth nor, to take another example, are there any large scale RCTs on the benefits of routine ultrasound screening in pregnancy. The model of science employed has a tendency to investigate ever more advanced technical solutions to human problems. Alongside this it would be naïve to ignore the role of commercial interests in funding research; 'where health is framed by a constant expectation of danger there is money to be made in providing investigative, preventative or curative products to counteract the risks' (Page 10). There is no commercial interest in investigating normal birth.

I had been looking forward to reading Nicky Leap and Tricia Anderson's essay on 'the role of pain in normal birth and the empowerment of women' so was pleased to find this in the first section: it met all my expectations. I agree that pain plays a big part in childbirth and has its uses and I think it would benefit every woman contemplating birth to consider their arguments.

The second section starts with a chapter which is collaboration between the NCT and AIMS, written by Beverley Beech and Belinda Phipps. They look at women's birth experiences and the effects on their lives, including post traumatic stress reactions and deal with the definitions of normality and what they mean. This is a clear and, in my view, unarguable case which needs underlining. They outline the paradox that despite the successful campaigning over the last fifty years by childbirth organisations, we have witnessed not just the increase in caesarean sections but also the insidious acceptance of interventions which are not clearly of benefit. Subsequent chapters deal with midwives' practice, in the UK and in New Zealand and they underline how easy it is for midwives to be pushed, often against their wishes, into an acceptance of medical thinking and procedures.

the RCT has not helped us with such important and basic questions as the relative safety of hospital birth compared with home birth

The third section, 'Evidence and debate' concludes the book with some more optimistic writing on normality, for example 'Promoting normal birth: weighing the evidence' by Dennis Walsh. I particularly enjoyed reading the chapter, 'Fetal to neonatal transition: first do no harm', and its straightforward account of what harm is done to both mothers and babies by the usual early cord clamping and removal of baby. I have felt that many women expecting their first babies find it almost impossible to imagine the moment after the moment of birth and can be unprepared for the barbarity of a managed third stage. 'The current birthing environment is a contested context in which medicalisation remained the dominant construction of birth …There is increasing intervention in the birthing process and increasing normalisation of intervention despite midwives' efforts to protect normal birth'.

The conclusion on reading this book is that labour and birth are being increasingly centralised in mega units and intervention rates are escalating all the time. A vicious circle of iatrogenesis feeding yet more litigation and yet more defensive practice is becoming apparent.

So I found this a tough book to read and the message is not very cheerful but this is a book which could equip midwives to be aware and prepared to fight. It is also a book that lays out for us what the nature of the task is to wrest the possibility of normal birth back as a real option for women in Britain.

Gill Boden

Could it have been different?

I am writing to say thank you to you for printing the story of Alison's birth in AIMS Journal Vol:21 No:1. I had a similar experience at my local maternity unit and I am still suffering from PTSD and depression 3 years later. I still wish that I had opted for a planned caesarean and if I have another baby I will ask for one because I can't face being like that again.

I wish that I had been able to complain, but since my baby was born I have felt that it was my body that could not give birth, and part of me still thinks that if I had been built different I would have been able to deliver my son naturally without all the nightmare messing about we got. I also wonder if he had been born naturally would I have been able to feed him myself. I have hated giving him formula, but I was so exhausted after the birth I didn't have a choice.

After reading this I wonder if I had got more privacy and time if I would not have needed the suction help and would have not had so many stitches. Alison is very strong to have known what was wrong and to try to get people to listen to her. I really hope her letters etc. have made a difference, she deserves it.

Sally Jones

I didn't have a choice

Breech, Twins, Home!

I had an unexpected breech at home three years ago.

My twins were born at home as I was lucky enough to have the wonderful Chris Warren and her colleague Michelle from Yorkshire Storks. It was a lovely experience.

Although I'd had a recent scan showing normal positioning, my first twin presented breech and Chris's words 'I can see hair' were soon followed by 'Would you like to turn onto all fours?' I did so, with my head and shoulders supported by my husband (one of my nicest memories of the birth) and what I thought was the head coming out was in fact his body. She then told me he was coming 'buttocks first' and I knew that with his head still inside I just had to relax as much as I could. All Chris did was support him. They later told me he was kicking his legs at this point. It seemed an age but actually I don't think it was. Next thing he was there and it was only after all was done that I realised Michelle had been ready with the oxygen once they'd seen he was breech.

That's it really, simple as that. The next twin just zoomed out, head-first, minutes later while I was turning back over and trying to look at the first on the bed, good job Chris correctly interpreted my words 'I can't really concentrate on him' and stood at the edge of the bed to catch!

This story isn't to say that anyone can give birth to a breech baby at home, but I think it shows how ridiculous it is to say that a Caesarean is the only way when a baby is breech. It also makes me feel sad for those who are transferred to hospital from home at this delicate stage of the birth just because community midwives are not able to handle breech.

There are other aspects to this story, not relevant to the breech issue but that present challenges to the way birth is done in the NHS: -

• I chose Chris because the NHS wouldn't let me have a home birth due to my first-born having weighed 10lb 3oz and the community midwives were 'afraid'. The AIMS helpline was invaluable to me.

• Having had no routine scan, the twins were discovered at 34 weeks and so I avoided all the frequent scans and other expensive medical nervousness that twins are normally exposed to.

• My waters broke three weeks before the boys were born and carried on leaking copiously. I politely said no to intrusive cervix 'scraping', took my temp several times a day and tried to rest to avoid pre-term labour. We now think the water was from an outer bag. (Birth was at 37 weeks.)

• I tested positive for strep B but, after some research I decided to say no to antibiotics unless one of the babies got a temperature.

• The labour was a straightforward progression spent lazing on my bed reading magazines until I couldn't concentrate and Chris decided she ought to come over -- she arrived an hour before the birth, gave me rescue remedy when I thought I couldn't cope as I went through transition.

• I never at any time did any conscious 'pushing' and they birthed themselves.

• The twins were born a few weeks after my 40th birthday so I'm no spring chicken!

Caroline Hind

Home birth hypocrisy

What an interesting magazine edition (AIMS Journal Vol:20 No:2 2008) but what a depressing situation it is in most of the other European Countries.

A thought that struck me about the fact that home birth has almost been abolished in Hungary due to a tragedy happening, was that, when a tragedy happens due to unnecessary Caesarean section (which increases the maternal mortality and morbidity rates anyway) there is NEVER any mention of banning Caesarean sections and hospital births as a result of this.

The situation is so hypocritical in the extreme. It shows how much more we all have to fight for.

Chrissie Haines

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

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

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

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

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 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

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

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

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

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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

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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

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Noticeboard

The Forum on Maternity & the Newborn

Do the communication styles of midwives and doctors affect the physical and psychological outcomes for mother and baby?

Thursday 28 January 2010
5:30pm
Contact Andrea Török
Academic Department
The Royal Society of Medicine
1 Wimpole Street,
London, W1G 0A
email: maternity@rsm.ac.uk
tel: 020 7290 2986
www.rsm.ac.uk/academ/mbj106.php

The Forum on Maternity & the Newborn

How do we develop tomorrow's leaders for safe maternity care in the UK and globally?

Thursday 18 February 2010
9am
Contact Andrea Török
Academic Department
The Royal Society of Medicine
1 Wimpole Street,
London, W1G 0A
email: maternity@rsm.ac.uk
tel: 020 7290 2986
www.rsm.ac.uk/academ/mbj106.php

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7th January 2010
Durham
International speakers discussing the latest research into the biology of mother-infant behaviour and implications for delivery, postnatal care, breastfeeding support.

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www.dur.ac.uk/sleep.lab

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