AIMS For a better birth...

Reflections of an ex-midwife

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A woman remembers the birth of each child for her entire life, and as we can see from the stories in this September issue of the AIMS journal, her account is often passed to her children and her children's children. In these reflections, Dot shows how the care and the antenatal education the parents receive, can shape that story for better or for worse.



By Dot Parry

Preparing parents for a positive birth experience has been my passion since I qualified as an antenatal educator over 30 years ago. I went on to train as a midwife and led antenatal education within the NHS, as well as providing one to one education to individual clients as part of my midwifery role. I stopped practising as a midwife in the NHS a little over 10 years ago. I've kept contact with my colleagues as they work through the closures, the changes in policy, the erosion of community midwifery support, the staffing shortages, and the immense challenges of COVID. I continue to work as a birth educator and tutor to people training to take on that role.

In 1996 I was a student midwife mentored by a wonderful group of women working in Reddish, Stockport. The team provided continuity of care to all the women in their patch, regardless of the complexity of their pregnancy. We ran community clinics, cared for people at home and in the hospital, and visited postnatally for up to 28 days. I learned a lot! The relationship the clients had with their midwives meant that their basic care was undertaken alongside deeper, holistic support for the family. It was intense but rewarding work.

One afternoon my main mentor (J) arranged for us to meet in the delivery suite to take over the care of a first-time mum who was being induced. Our client (let's call her Sally) had been on the antenatal ward for a few days, and we'd popped in to see her a couple of times already. J said that we should have a look at

the delivery room before Sally arrived. We spent some time rearranging the room, bringing a beanbag in to create a nesting area, pushing the bed up against the wall, working out where we could plug in the CTG [1] so that Sally could move around while being monitored. I went to the ward to collect Sally and her partner. Sally looked anxious as we entered the delivery suite but when she walked into her room to see the dimmed lights, the rocking chair and J finding a good station on the radio, she visibly relaxed. The induction was successful. There were times when we had to turn down the Syntocinon infusion[2] because she was producing so much of her own oxytocin. The birth was beautiful, as unbothered as it could be. The baby was born safely into a calm, loving environment.

Fast forward to my second year as a qualified midwife. I was working on a mixed antenatal/postnatal ward in a large maternity unit that catered for both low and high tech births. I rotated on to the delivery suite and loved the work there so much. The relationship between the midwifery, support, and obstetric staff was excellent and I felt well supported by the whole team. One day I witnessed prostaglandin-induced uterine hyperstimulation[3] that resulted in a precipitate birth in a side room. Nobody did anything wrong, the staff all responded to the situation effectively and efficiently - but it was rubbish. The blinds on the windows were broken so it was bright. The woman only had one pillow because I'd not had time to find any more. And there was a constant stream of people coming in to do the theatre prep until we bustled them all out because the baby was visible and advancing quickly. The baby was fine. There were no stitches needed, no postpartum haemorrhage. We talked on the postnatal ward the next day. The woman was shocked by what had happened but relieved it was all over. I don't know how her long-term mental health fared because I didn't see her again.

Throughout my midwifery career the lessons learned from these two situations stayed with me as I went on to care for many more people having their labours induced. I never forgot the importance of the birth environment, championing improvements to the hospitals and birth centres where I worked, as well as doing a small amount of consultancy work for other Trusts. I also never forgot how careful one needs to be when using prostaglandins and how vital it is to be available even when you have five other things you're supposed to be doing. Over the last 10 years those five things have probably doubled for the midwives who remain.

I currently run antenatal courses for two organisations. For one I teach on-line courses for parents all over the UK and sometimes overseas. For the other I run small group courses. In the small group courses, I usually have one or two clients planning a caesarean birth. In the rest of the group at least 50% will be offered induction of labour. The reasons for the high induction rates are well discussed elsewhere[4]. I'm able to meet my antenatal class clients after the birth and to hear their birth stories. I ask them what they wish they had known so that I can prepare the next group more effectively. I listen to their birth stories and reflect on my practice, always aiming to be a better educator.

Until recently, my approach to education around induction has been to focus on facts about the process itself, and on decision making and negotiation skills for the parents. I encouraged the parents to explore acronyms to prompt them to ask the right questions when discussing induction with their caregivers. We would also discuss the challenges that those caregivers face in a very busy system. I admit I wanted some

of them to change their minds through this process, to maybe opt for the alternative care pathway of watchful waiting until their baby was ready to be born and if there were no medical complications.

“I knew it would take a long time, but I didn’t think it would take forever!”

There are many instances of expectant parents who have been told induction is necessary for their baby’s safety and they are admitted to hospital. But then the pressures on the service mean that they wait hours and sometimes days for every step of the process.

In October 2021 a client messaged me asking for a chat. We talked on the phone for a while as she told me her situation. She had been unwell through most of her pregnancy and was relieved to have reached a point in her pregnancy where induction would be possible. Changes in her condition meant that her baby needed to be born soon but not urgently, so induction rather than caesarean seemed like the right course of action. She was fully aware that induction of labour can take time, but she had worked out that even with the slowest progress, she would have a baby in her arms by Wednesday lunchtime. But every dose of prostaglandin had been delayed as the obstetric unit was full and she was currently waiting for a space on the labour ward to have her membranes ruptured. She was already four days into a three-day process, not really in labour, and losing hope. The support from the ward midwives had been wonderful as they sought to support *all* the people being induced, re-prioritising as individual needs changed, while caring for other people with a variety of antenatal complications. We talked about what she needed most right now, and she worked out that it was some privacy and some rest. She spoke to the midwives who had no idea how distressed she was because she had been so lovely with them and didn’t like to cause a fuss when they were so busy. Together they hatched a plan that she should go home overnight, with the understanding that they would call her if the situation in the hospital resolved. She returned the following day, ready to resume the induction. Her baby was born by caesarean section another 24 hours later, the parenting journey beginning in a haze of exhaustion. She told me afterwards that the midwives had cared for her the best they could, and she felt extremely grateful to them for her care. She had a healthy baby after all and that was the main thing. But she was deeply traumatised by the events she’d lived through and is still struggling to come to terms with what felt like a dangerous situation for her and her baby.

Induction can work well, but queueing on an antenatal ward is not the right environment for the process to be successful. Too many people being induced makes this situation inevitable. The impact of COVID absences is simply exacerbating a problem that was already deeply entrenched.

Parents who have been told that induction is urgent, but then experience delays that prolong the process over days, might feel like they have only narrowly avoided disaster. One client is still struggling months after an induction that ended in a category 1 caesarean section under general anaesthetic. She was worried about her baby's condition but couldn't get anyone to check things out on the induction ward as they were 'spinning too many plates'. She's now terrified that she will miss something important about her baby's condition, worried that not enough people are checking her baby's well being still, trying not to make too much of a fuss because everyone is overstretched.

With the recent changes in the NICE guidance around induction of labour, some clients are choosing caesarean birth to avoid the marathon induction stories their friends and family tell them about. With the effects of the Ockenden report only beginning to be felt, the caesarean rate in the UK is likely to rise. Caesarean birth can be beautiful, but as the numbers go up, it might be harder to achieve a family centred caesarean service.

As a birth educator I strive to help parents work towards a positive as well as safe birth whether the labour is spontaneous or induced, or the birth is by caesarean. I have seen examples of 'teaching for compliance' or 'telling them how it is'. This is as effective as telling expectant parents that their baby won't sleep much so neither will they. They know this. What they need is an understanding of the normal range of baby sleep patterns, to work on strategies for maximising stamina, to put support in place, to think about how they might manage conflict when they are sleep deprived, and to consider ways to take care of their mental and physical health.

If we just teach that 'this is how it is', there is no hope for positive change nor for people to take responsibility for the elements of the birth they *can* influence - staying active in pregnancy, moving their bodies during the birth to help the baby on their journey, speaking up when they are aware that something isn't right or that they need to do things a different way, preserving their sense of self through the process at the same time as keeping themselves and their babies safe.

So I'm noticing that my approach to teaching about induction is changing.

- My clients are sometimes reluctant to use decision making templates to ask their caregivers for the pros/cons/alternatives of a suggested course of action. I suggest that in order for their bodies to get on with having a baby they need to feel safe and supported. If they have unanswered questions, or if they don't really believe that they need to be induced, their body might not be able to go along with the process. Care providers are under immense pressure and are not infallible. Sometimes the way forward changes if the implications of the plan and any alternatives are explored - sometimes not - but the very act of exploring and deciding means that parents can then look back and know they made *their* best decision and that they were not forced or coerced in any way.
- We discuss absolute risks and relative risks. This understanding is useful in so many contexts around birth and parenting. Some of them use this in the discussions with their caregivers about induction plans - many don't but they still have the tool for later use.

- We have an honest discussion about the option of a caesarean and look at the NICE guidance to see what their midwives and doctors are working towards.
- I encourage the clients to look back at some relevant life skills. Most of them will have endured tedious journeys in overcrowded trains or long waits at an airport. They may have developed some brilliant coping strategies to help themselves in these situations, strategies that could be adapted to enable them to create some tranquillity on a busy antenatal ward.
- We explore the elements of the birth process they can influence - staying mobile or resting in a beautiful side lying position, keeping the oxytocin levels up, making positive connections with their midwives, receiving support from a birth partner who understands them. Taking responsibility for these elements of the birth means that their midwife can do their job even if their resources are stretched.

These strategies shouldn't have to be the answer. Midwives should be able to prepare the birth room, care for people they know, spend time in the labour room, help to maximise the oxytocin. But until there are a lot more midwives, we have to do something to help with the status quo.

I'm seeing some interesting changes. Last month a client messaged to ask for a chat part way through her induction. She told me that she had asked for a single room as soon as possible because the four bedded bay was so noisy. She described how the busy midwife had spent over half an hour with her trying to get a decent CTG trace on her very active baby, simultaneously helping her to work through the pros and cons of continuing with the induction or going on the list for a caesarean in the morning. She told me about the comfort measures she had brought with her and how much her little aromatherapy stick and her pillow were helping her to feel calm and at home. It was good to hear her working it all out for herself, ably supported by a partner who admitted he was pretty terrified before they came to the course. She laboured effectively overnight and gave birth in the small hours. She told me she would never forget those wonderful midwives.

Theirs was a safe, empowering induced labour and birth. Two new parents who felt on top of the world as they welcomed their healthy little baby. No flashbacks. No postnatal anxiety. Midwives who got to do their job.

Author Bio: Dot Parry qualified as an antenatal educator over 30 years ago. She went on to train as a midwife and to lead antenatal education within the NHS, as well as providing one to one education to individual clients as part of her midwifery role. Dot continues to work as a birth educator and tutor to people training to take on that role.

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[1] Editor's note: Cardiotocography (CTG) is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour.

[2] Editor's note: Syntocinon is artificial oxytocin and is used via a drip (an infusion) to start labour

contractions or to strengthen them.

[3] Editor's note: Prostaglandin is the drug used to help prepare the cervix prior to induction of labour. It can occasionally cause uterine hyperstimulation which results in unnaturally strong contractions that can affect the baby's heart rate.

[4] AIMS (2022) Induction: love's labours lost?https://www.aims.org.uk/journal/item/birth-partner-review