AIMS For a better birth...

Editorial: I am writing to make a complaint

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By Alex Smith

Welcome to the 2024 March issue of the AIMS journal. The theme for this quarter focuses on the experience and process of making a complaint.

Over the years I have made two complaints about NHS staff. Neither of them was directly related to maternity care, but the parallels were striking. Both complaints included:

- not being listened to
- no regard or respect for approaching the consent process in the proper way
- no regard or respect for the knowledge we held
- extreme pressure (amounting to bullying) to comply with a treatment that was not in line with NICE guidelines in one instance, and strongly challenged by current research in the other
- no concern for holistic care needs
- defensiveness and irritation from staff who clearly felt thwarted in their authority by our non-compliance
- and in one case, three (seemingly malicious) safeguarding referrals from nurses about us - all of which (we later read in the notes) were turned down by the safeguarding team with increasing levels of annoyance expressed by the team towards the nurses.

Unfortunately, these were not our first experiences of poor care (only the first we had complained about). We had learned from earlier experiences that we often bitterly regretted not trusting ourselves, not speaking up, and not standing our ground. I want to give examples at this point but they are too emotive. Suffice to say, we became determined to stand our ground in situations where standard care was inappropriate or unacceptable, while remaining calm, clear, courteous, reasoned - and within our rights. That should do it, I thought.

But no, even now, if I or a family member are in a medical situation where a little ground-standing is required, it feels as if daggers have been drawn (*not every time*, but often enough). Expectant parents instinctively anticipate the possibility of this type of response, when they explain that they did not assert themselves in a maternity care situation for fear of 'getting their backs up'. I wrote in one complaint that it seemed as if anything short of grateful compliance was a trigger for the nurses, that anything else simply did not 'compute'. At points where I remember feeling frustrated and distressed in trying to advocate for my dying mother's preferences (at her request), I found from their notes that I was being perceived as *difficult and hostile* - and when I succeeded in supporting her (and I did), this was when the safeguarding referrals began - echoing the significant rise in referrals to social services for declining aspects of care, that parents report to us on the AIMS helpline. These incidents resulted in lasting feelings of trauma yet, in an academic way, I also found them fascinating.

The question I returned to again and again was why?

- **Why were these (presumably perfectly nice) nurses not practising in line with the Royal College of Nursing's excellent Principles of Nursing?**[1] These principles are intended as a measurement tool for quality improvement and to enable providers and patients to know what quality nursing looks like. They include some wonderful words:



Warming words are also found in 'The Code', the professional standards of practice and behaviour for nurses, midwives and nursing associates[2]. The first standard set out in The Code includes the requirements to:

> *Treat people with kindness, respect and compassion…avoid making assumptions and recognise diversity and individual choice…respect and uphold people's human rights.*

When nursing and midwifery care measures up to these standards, there is very little cause for complaint.

- **Why were the nurses so fixated on the local protocol?** In both of my complaint situations adherence to the hospital protocol and 'what we always do' was literally the only thing that seemed to drive care. It was their unshakeable modus operandi. I could not understand why senior nurses were unaware of up-to-date research and unable to respond to it even when I had it in my hands for them to see. I could not understand why they were unaware that there were legitimate points of debate to be had. In both situations they would or could not engage in respectful nuanced discussion about treatment options when we invited this, but just looked at us like proverbial rabbits in the headlights - and then reiterated the protocol as if this was all they were programmed to say. If they had been on a screen I might have wondered if they were AI generated. This felt so unreal that I actually felt gaslighted. I know that some maternity service users will recognise this.

  "Obstetric providers can gaslight mothers when they deny mothers' realities. Gaslighting includes denials of mothers' humanity, knowledge, judgments or feelings. All four denials work to render mothers noncredible and their claims illegible."[3]

- **Why did the nurses appear to have no idea about consent?** Not only did the nurses in both situations assume that the patient's consent to treatment was a given, they seemed shocked, puzzled and annoyed when they were asked not to proceed. The Montgomery ruling about consent[4] was fairly recent at the time (and doctors and nurses can't know everything), so I

> reminded them that gaining consent now required discussion of the options, up-to-date information, time to consider the decision without undue pressure or coercion, and respect for the decision even if they did not agree. I actually thought that this would get us back on track, but no. in both cases, efforts to gain our obedience were stepped up exponentially. It is still an absolute mystery to me why they didn't just say, "Of course, that's fine", and then document our decision in the notes. In both of my complaint situations that simple response would have made the world of difference.

When I reflect on my complaint situations and their similarities to the complaints of maternity service users, and ask that question 'why?' - why did they behave this way? - I find myself boiling it down to *ignorance* or *malice*. Harsh words, but when nurses, midwives or doctors behave in a way where they appear to have: no respect for the principles of their professional practice; no respect for individualised care; and no awareness of their legal duties in approaching the consent process in the proper way - this can only be for one of two reasons. They either do not know about these things and do not know that forced compliance is harmful (ignorance) or they do know, but choose to ignore this despitethe harm[5] they know it will cause (malice). In discussion with others, an almost identical analytical conclusion was proposed but with the gentler words of *naivety* or *wilfulness*, however, it boils down to the same thing.

Of course, the vast majority of nurses, midwives and doctors do not get up in the morning and go to work meaning to be naive or wilful, so there is another '*why*' to ask - why do caring and hardworking practitioners open themselves to being complained about? The professional principles, codes of practice, and the correct approach to seeking consent, would protect them as much as they would the patient or maternity service user - if only they were embraced. In 2020, a study[6] showed that since the Montgomery ruling the number of settled claims directly related to the patient not being fully informed before consenting to treatment rose four-fold, and cases where not being fully informed was a contributory cause of the complaint, settled claims rose nearly ten-fold. No one wants an experience of care that leaves them needing to complain, and no one wants to be complained about. The answer is so simple; the guidelines for it are already in place, but here they are again:

> *Treat people with kindness, respect and compassion…avoid making assumptions and recognise diversity and individual choice…respect and uphold people's human rights.*

Did my letters of complaint change things for the better? I wish I knew. I have to say that in 2019, the complaint regarding the nurses who visited my late mother resulted in the promise of county-wide workshops for community nurses, both on *practising with emotional intelligence* and on updating their understanding of consent. Given the disruption to services caused by the pandemic, I do not imagine for one moment that this happened, but it still felt like a good result.

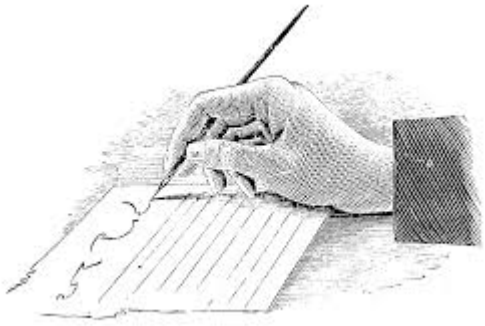


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We open this March issue with Julia Mihaylov's gently-told personal account of a hospital mistake that could have ended very differently had she not trusted herself. This is followed by Grace Hall sharing the very unsettling story of the birth of her first baby, the events of which continue to haunt her today. While her own complaint at the time got her nowhere - possibly because some of her medical notes mysteriously went missing - Grace believes that the complaint process can be beneficial. Laura Mullarkey goes on to compare her recent experiences of complaining about her NHS antenatal care, to making a regular consumer complaint. Laura's comparison is very measured considering that her and her baby's life had been put in jeopardy by her GP's failure to provide medical treatment, but Gemma Mckenzie pulls no punches in describing how her experience of obstetric violence, and then the denial of this in a way that amounted to gaslighting, led to her rejecting the futility of the formal complaint and choosing to play the long game instead. Get your crochet hooks ready! While the complaint process often does end up feeling futile, Anne Glover notes that some of her doula clients receive really encouraging responses from their complaints. Perhaps the process of complaining is like housework in that it doesn't appear to make a difference - unless we don't do it. Unfortunately, as Gemma McKenzie experienced, women are often too bewildered immediately after the birth to make a complaint at that time and yet the troubled feelings do not go away. Reading the AIMS guide to Resolution After Birth, reviewed in this issue by Sakina Ballard, can, in Sakina's words, ease some of the bewilderment.

Thanks to women speaking up about their experiences, the first parliamentary debate on birth trauma took place in the House of Commons in October 2023. AIMS volunteer Elle Gundry reports on the significance of this, and for those of you who may be unsure about how to speak up, Nadia Higson gives a detailed account of how to make a complaint. Members of The Campaigns Team tell us about attending The British Intrapartum Care Society (BICS) conference, and Georgia Clancy and Catrin Evans ask how digital consultations can best be used in maternity care. Years ago, I remember joking that one day maternity care would be offered online (thinking this the epitome of the world gone mad), but here we are and maybe there are some good things to be said. However, the CORE implementation principles that Georgia and Catrin highlight should perhaps be respected with particular regard to the racial and socioeconomic inequalities that, according to Catharine Hart in her piece on the latest MBRRACE reports, continue and even widen. In our penultimate spot for this issue, and on a happier note, Stephanie Ernst tells us about screening for twins and why good guidelines matter. Finally, to bring the March issue

to a close, The Aims Campaigns Team tell us what they have been up to during the last quarter.

We are very grateful to all the volunteers who help in the production of our Journal: our authors, peer reviewers, proofreaders, website uploaders and, of course, our readers and supporters. This edition especially benefited from the help of Anne Glover, Danielle Gilmour, Katherine Revell, Julia Mihaylov, Salli Ward and Josey Smith.

The theme for the June issue of the AIMS journal is *maternal morbidity*. This would include pre-existing conditions that may be aggravated by pregnancy, or new conditions that arise as a result of pregnancy or childbirth. If you have experience or insight you would like to share, I would love to hear from you. Please email: alex.smith@aims.org.uk

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[1] RCN (updated 2021) The Principles of Nursing - click on link to their poster www.rcn.org.uk/Professional-Development/publications/pub-003864

[2] NMC (Nursing and Midwifery Council) The Code: the professional standards of practice and behaviour for nurses, midwives and nursing associates www.nmc.org.uk/standards/code

[3] Priya Fielding-Singh, Amelia Dmowska (2022) Obstetric gaslighting and the denial of mothers' realities, Social Science & Medicine,Volume 301 www.sciencedirect.com/science/article/abs/pii/S0277953622002441#preview-section-cited-by

[4] Ashworth E. (2021) The Montgomery ruling and your birth rights www.aims.org.uk/journal/item/montgomery-consent-law

[5] Journal Vol. 34, No. 2 (2022) — The Sound of Violence www.aims.org.uk/journal/index/34/2

[6] D S Wald, J P Bestwick, P Kelly, The effect of the Montgomery judgement on settled claims against the National Health Service due to failure to inform before giving consent to treatment,*QJM: An International Journal of Medicine*, Volume 113, Issue 10, October 2020, Pages 721–725, https://doi.org/10.1093/qjmed/hcaa082