AIMS For a better birth...

Editorial: Improving maternity care for all

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By Alex Smith

Welcome to the December 2025 issue of the AIMS journal. Building on last summer's edition, 'When the Mother is Unwell',[1] and with AIMS volunteer Jo Dagustun's support, we have invited theMuM PreDict research project to share what they have been finding out about improving the experience of maternity care for women who embark on pregnancy already living with two or more long-term medical conditions and who are expected to have a more complex and high-risk pregnancy.

MuM PreDiCT stands for Multimorbidity and Pregnancy: Determinants, Clusters, Consequences and Trajectories, which is research-talk. The issue opens with the project's Patient and Public Involvement lead and co-investigator, Rachel Plachcinski, introducing the project and explaining the gap in the research and guidance that led to it.

In the current birth climate it is easy to believe that *every* birth is extremely risky, and so my personal default-setting response to the term 'high risk' is a powerful sense of suspended judgement. On the one hand this term is all too often used in a grossly inflated sense when a woman, for one reason or more, has a *very slightly* higher chance of experiencing an adverse outcome than a woman without those reasons for concern. I emphasise 'very slightly' because the actual level of increased risk, and the fact that this is very small, is usually not made clear to the women who have been labelled in that way. These women may well be denied the very aspects of care that are known to reduce risk, namely: midwife-led care;continuity of carer; personalised care and a choice of where to give birth - all combined with good inter-professional communication. I have previously addressed the harm that this can do in,The label of 'high risk'.[2]

On the other hand, my suspended judgement allows me to wait and to listen, and just occasionally, the woman goes on to explain her extraordinary medical history, often involving conditions that she was living with from before her pregnancy. This is a very different matter. Years ago, women who lived with chronic health conditions may have been advised not to marry, as marriage, in those days, implied the inevitability of pregnancy. Today, advances in the medical management of conditions like diabetes or epilepsy have made pregnancy a much safer possibility, but a possibility that still requires careful medical care. In those exceptional situations, one hopes that this medical care will be timely, personalised, respectful and all joined up by really good communication between the different specialists involved. Sometimes it is, but sometimes it isn't. In this journal, we hear from four mothers who had mixed experiences: Mary Smith, Jennifer Pearce, Etomby Namme and Sara Javid. It is women like Mary, Jennifer, Etomby and Sara who are the concern of the Mum PreDICT project and of our journal theme for this issue.

The overuse of the words 'complex' and 'high risk' have done a massive disservice to the women who really do need close and ongoing medical support. Casting a very wide net and setting a very low bar for the diagnosis of a condition - one that is not causing major symptoms and would have either passed unnoticed or been considered as part of normal life - places a lot of essentially healthy women into a system intended for those who are unwell. For example, people are now medicated for *pre*-diabetes and for 'high' blood pressure that was considered normal a few years ago.[3][4][5] The intentions are good,[6] but the evidence of benefit,[7] less so. Lowering the threshold for diagnosis (both before and during pregnancy) adds pressure to an already over-taxed service, and means that valuable resources are spread too thinly, potentially putting those in actual need of medical support at greater risk. Overdiagnosis and over-treatment is therefore an ethical issue of real importance for us all.[8]

The routine medical surveillance and hospitalisation of almost all pregnant and labouring women has led to a change in midwifery training. A third year midwifery student told me recently that her course provided only two hours of tuition on birth physiology. The system is now training would-be midwives as 'obstetric nurses', and their training can be completed without them ever having seen a truly physiological birth, and without any (or virtually any) training into how to support the physiological process. This lack of understanding about birth physiology in those regarded as being 'the experts', means that the physiological process is routinely and unwittingly disrupted, adding a layer of iatrogenic harm to anyone giving birth in hospital - including those with long term health conditions.

The principles that support undisturbed physiological birth, enhance every birth.

AIMS strongly believes that a physiology-informed approach to care for ALL women, enhances the safety and satisfaction of ALL women and their babies - including those with serious health conditions.. Read more about this in the AIMS position paper calling for a Physiology-Informed Maternity Service.

In addition, AIMS upholds the human right of respect for a person's physical and mental integrity, so we get a bit picky about the use of language. One example in maternity care is the widely used but misleading term 'shared decision-making'. Legally, it is the mother alone who makes any decision about

what happens to her body. Her wholehearted consent is required for any and every aspect of her care, and she is free to withhold it. Read more about this in the AIMS positionDecision Making in Maternity. Doctors and midwives are responsible for the quality of the care they give, and for the manner in which it is offered, but not for the woman herself. This leaves them free to provide truly personalised care, which is the safest there is and exactly what the MUM PreDICT project is exploring.



In this issue MuM-PreDiCT parent advisory group member,Sally Darby, explores the different ways of explaining levels of risks so that decisions about care can be fully informed.Dr Megha Singh, and Dr Jingya Wang from the MuM-PreDiCT project, explain the dilemmas faced when finding the safest balance of medication for pregnant women living with two or more health conditions, whileZoe Vowles, a midwife working on the MuM-PreDiCT project, looks at the need for excellent communication between the different teams involved in a woman's care. Without joined-up care, women often receive conflicting advice. Researchers Siang Ing Lee and Ngawai Moss report on the qualitative study they conducted into this serious concern. Another issue for pregnant women with chronic health conditions is that they have to attend additional hospital appointments, often in different sites.Doctors Pavithra Warnakulasooriya and Mairead Black explore the impact of this on women, especially when they have to travel a long way for maternity care. A theme running through the MuM PreDiCT project is the importance of listening to the women who use maternity services; Natalie Whyte, a member of the MuM-PreDiCT Parent Advisory Group, explains why she is so passionate about amplifying their voices. And the final member of the Mum PreDiCT project, Professor of Artificial Intelligence,Christopher Yau, considers the role of Artificial Intelligence in maternity care.

In addition to the MuM PreDiCT contributions we welcome back Independent MidwifeFedwa Barrak who explains how care can be personalised even in more complex pregnancies and why this is so important., and AIMS volunteer, Nadia Higson reflects on the launch of the MBRRACE report 2025, which, this year, included a series of case studies of mothers with complex needs who died after failures to provide holistic care and support. We also have our regularBirth Activists Briefing that, in this issue, highlights the key findings from the recently published NMPA State of the Nation Report for 2023, and raises some queries/ suggestions for further exploration. MidwifeClaire Feeley and AIMS volunteer Jo Dagustun remind us about the transformative power of the right midwife. Our penultimate article highlights the time that AIMS volunteers give to research projects and what we feel we contribute, and we round up with a general look at all of the things that theAIMS Campaigns Team have been up to since

August.



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The theme for the March 2026 issue of the AIMS journal asks the question: "What is the ideal approach to antenatal education - what would make a truly positive difference?" If you would like to share your thoughts on this, or if you would like to contribute your ideas for future authors and journal themes, please contact Alex at: alex.smith@aims.org.uk

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