AIMS For a better birth...

'SO WHAT'S YOUR PROBLEM'

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Alice Charlwood wonders why so few women complain about poor maternity care

After 30 hours of early labour at home, and having decided it was time to move to hospital, this is how one woman was greeted by a surly midwife at the door of a central London birth unit. The woman and her partner quickly realised that this gum-chewing, unfriendly creature was going to be more of a hindrance than a help towards the kind of birth they aspired to, and took steps to have her replaced by another midwife who turned out to be, as they put it, 'not dissimilar.' Of the five or six different midwives they encountered on that day, they rated only one as 'fantastic.'

This was a labour that, unsurprisingly, required acceleration but, gallantly, the couple managed to unravel the 'spaghetti' of drips and CTG wires to stand and rock and breathe together through fierce Syntocinon contractions, and managed this ordeal without drugs. At last, the tell-tale signs of labour coming to an end and the onset of the urge to push became apparent. Was a midwife on hand to congratulate, encourage and facilitate a normal birth? Unfortunately not. After all the measures taken thus far to speed the process up, now the mother was told not to surrender to the urge to push because, inconveniently, the sensitive transition from one stage to another coincided with a shift change and noone was available to examine her. Some time passed before a new midwife appeared, who then insisted the mother get on the bed to be examined. By now the spontaneous urge to push was waning, and it disappeared altogether in the midst of the debate that ensued about the mother's informed choice to avoid the lithotomy position she was being asked to adopt. When she gave up the argument and did as she was told her pushing was condemned as 'ineffective.' An instrumental delivery was only avoided, ultimately, because of her final huge expulsive effort just before forceps were used.

In the same week, in another hospital a mile or so up the road, another mother progressed slowly but surely to eight centimetres in the care of a very considerate and supportive birth centre midwife who, sadly, went off duty and was replaced by another who promptly insisted that the mother stop roaming around the room and lie down on the bed to be monitored. There were no problems with the baby apparently, but she was not permitted to get up again and dilation progressed no further. She was transferred a little later to the consultant unit, to a room with eight or nine people, several of whom took no notice of her whilst they conducted loud conversations on their mobile phones. The husband had heard that a situation like this was likely to hinder progress and raised this issue quite quietly and diplomatically with one of the doctors whose response was a screaming tantrum about what he saw as appalling disrespect to him as a qualified doctor.

What with one thing and another, the mother was, by now, extremely upset, and this was only compounded when several of the crowd around her urged her to 'get angry with your baby, get angry with your baby!' In this unconducive situation, again it's no surprise that eventually a caesarean was necessary and a lot of trauma to the mother and baby of one sort or another had to be endured, and a considerable sum of money spent postnatally on sorting it out. In what appears to be a catalogue of iatrogenic (caused by medical attention) complications and mismanagement, the mother later noticed a number of record-keeping errors in her notes, the most serious of which was that she had had two previous stillbirths, which she had not. Not even one.

This last couple were encouraged by several of the hospital staff, who witnessed the incident, to complain about the conduct of the doctor who shouted and yelled at them, and they did in fact do so before they were discharged. But, having raised that issue, they seem to have no appetite at the moment for bringing up other complaints, although they certainly have grounds to do so.

These are but two recent examples of the many troubling stories which women have shared with me, and one another, about distressing and disappointing birth experiences, and I often wonder why, when they complain so bitterly amongst themselves, do they so rarely complain to the hospitals. Is it because they are just relieved that they and the baby managed to sur vive and they prefer to put the painful experience behind them? Are they too busy and exhausted trying to adjust to parenthood and don't want to make a fuss?

I hear them rationalising the treatment they received on the grounds of safety, particularly the baby's safety, when it sometimes seems clear that serious questions should be raised about the real necessity of what was done. Despite anything they may have learnt beforehand about their potential for normal birth, maybe there's a part of them that didn't quite believe birth could be any better or any different, and they put their dire experiences down as inevitable. I often hear them speak of what happened in a resigned, philosophical way and then put a brave face on it, declaring that having their precious baby makes it all worth it.

In the last AIMS Journal, Volume 20 No 4, Denis Walsh pointed out the problems of herding low and high risk women into large centralised units which cannot respond to the needs of the former, and Gill Boden described the growing normalisation of intervention that creates a vicious cycle of iatrogenic problems, more and more litigation, and yet more defensive practice. Birth professionals are aware of these realities but perpetuate the myth that women have a reasonable expectation of giving birth normally in hospital ('normal' as defined by the working party who have produced the Normal Birth Consensus Statement), when all the evidence points to this being the rare exception rather than the rule.

Birth educators are sometimes criticised for giving women unrealistic expectations about what labour is like and their ability to cope with it, but perhaps a more deserved criticism is that we are not always open and honest enough about how unlikely a normal birth is in a hospital environment. It is not easy to disabuse pregnant women of their confidence in hospital as a place to achieve normal birth, and we may

avoid addressing the issue because we do not want to disillusion them or create any extra anticipatory fear or anxiety. Yet if we gloss over the evidence about this, are we colluding in the wider culture of deception about what's really going on?

How often do midwives reassure low-risk women that they will be free to do what they want in labour, but then ignore evidence-based guidelines and actually obstruct and constrain the mother's intuitive behaviour? This problem has been brought home to us again in the 2007 Healthcare Commission survey about positions women were in for birth that found that, on average, a paltry 12% of women were standing or squatting or kneeling. I accept that epidurals must be a contributory factor, but what are we to make of the news that the best hospital trust in the whole country in this respect managed only 31% of women giving birth in the natural positions that are constantly observed at home births, especially when so much evidence points to the increase in pain and instrumental birth in other, less physiological positions? Worse - what about the hospitals who had even fewer or, in a couple of cases, no women at all using such positions?

We've all heard of midwives who openly mock women aspiring to labour without drugs and seem hell-bent on sabotaging their efforts, yet regard themselves as experts in normal birth. Evidence-based practice that supports and promotes normal birth is set aside in favour of midwifery protocols that prioritise technology and the obstetric model of measuring, monitoring and management. The women's own wisdom is given no credit at all, and, as a result, countless women are suffering avoidable pain and hardship without complaint because they've been conditioned to think of this as 'normal birth' and so, apparently, not worth complaining about.

Even if we managed to change their expectations and they felt able to complain more, would it change anything for the better? Or is the system so hidebound and selfsatisfied about the rightness of its intentions, actions and outcomes that complainants are dismissed as litigious, misguided or mad? If more women complained, would anyone actually be listening? Who, in the existing hierarchy, would be willing to implement the change of culture and practice that would be necessary to address the complaints?

Is there any evidence about the effectiveness of complaining that points to real long-lasting change in individual practitioners or the unit they work in, in the wake of a complaint? I take heart from Ingrid Wall's story (page 8) about some improvements to postnatal care as a result of her complaint, as well as Vicki Williams's report (page 18) on one MSLC that is addressing complaints promptly, amending some policies and practices as a result of complaints, and running study days to improve communication and enhance patients' experiences. Another MSLC responded positively to Michelle Barnes's campaign to promote normality and reduce caesarean section rates (page 11), and is already noticing their normal birth rate increasing.

We have a wonderful example of what excellent, one- to-one, woman-centred midwifery can do for women, even in the face of a stillbirth, in Jenny Gaskell's story (page 22). This quality of care is so often what is lacking, as is the sort of undisturbed, hormone-enhancing environment that tends to make birth easier and safer. Adela Stockton explores ways of raising awareness of this and building confidence in

low-tech birth amongst parents-to-be (page 9), helping them protect their chances of a more positive and empowering birth experience. Sara Shah's persistence in trying to secure this for herself after a distressing first birth (page 19) resulted in her Trust employing an Independent Midwife for the home birth of her second baby.

Unlike Sara, a great many women still fail to grasp that their problematic labours may have stemmed from the way they were looked after (or, sadly, not looked after) in hospital. Yet even when they do realise there is something to complain about, it seems most have sussed out that to complain is to be on a hiding to nothing. This has certainly been Maria C's experience (page 5) - she is now five years into a painfully frustrating process which, as she says, seems designed to get people to give up. It is hard to know, in answer to the question at the top of the page, which is our greatest problem - women's reluctance to embark on a justifiable complaint, or the machinations of a complaints procedure that closes ranks and fails to address the avoidable tragedies and trauma women are suffering during birth.