AIMS For a better birth...

Caring for parents

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Gill Boden, Debbie Chippington Derrick and Shane Ridley talk about stillbirth

'Imagine a love so strong that saying hello and goodbye at the same time is worth all the sorrow.' (author unknown)

Instead of the joy of a new life, stillbirth means parents are faced with the loss of their baby. So, while routinely preparing women for stillbirth may not be appropriate, more openness might make it easier for those who find themselves in this extremely distressing situation. Lack of preparedness also means those who are supporting the parents through pregnancy and birth have a very important role to play.

Stillbirth is when a baby is born dead after 24 completed weeks of pregnancy; it includes babies who die before or during labour and those who show no signs of life when born. A baby born alive who then dies within seven days of birth is classified as a perinatal death, this overlaps with neonatal death where a baby dies in the first 28 days of life. When a baby dies in pregnancy before 24 weeks it is classified as a miscarriage. Although this Journal primarily focuses on stillbirth, the issues raised frequently apply just as much to miscarriage, perinatal or neonatal death.

The article by Amanda Hunter (page 9) details the support and training that Sands is able to provide, developed from years of experience of meeting the needs of parents. The report of the NPEU review of support available for loss in early and late pregnancy (page 17) provides details of successes in this area as well as issues that still need to be addressed, after miscarriage as well as stillbirth.

When a baby dies before birth, parents need to make plans for the birth. Brenda van der Kooy (page 6) discusses how these may be different from their previous plans and how, to avoid later regrets, parents should be given time to make decisions that are right for them. AIMS' experience is that a more medicalised birth is assumed when a baby has died, planned homebirths are often abandoned unnecessarily, and certainly homebirth is not usually offered as an alternative.

Much of the improvement in services and support has come about through the efforts of those who have experienced stillbirth. For example, Nicky Heppenstall (page 7) explains why professional photographers volunteer their services for UK parents whose baby has died.

Following a stillbirth parents will need to be helped to do what is right for them, organise a funeral, a burial place or other memorial, and to cope through the days, weeks, months and years ahead.

In this Journal, Shane Ridley (page 24) looks back on the difference made by the support she and her

husband received. If there are other children they will need support in grieving for their lost sibling. Gill Boden (page 26) reviews three books for young children exploring things they may experience following a stillbirth or miscarriage. Whilst putting together this Journal we were struck by how often we encountered the issue of women requesting a caesarean.

When a baby dies before birth, mothers often want to end their pregnancy as quickly as possible and not have to birth a dead baby, something a caesarean section would achieve. However, evidence-based practice is to encourage vaginal birth to avoid compromising the next pregnancy with a uterine scar. We had much discussion about whether the lack of emphasis on the risks of this common surgery is affecting women's reactions. We feel that there is an issue here that needs exploring further, as the risks of caesareans seem to be being made much clearer to women facing a stillbirth, while they are often minimised for a live baby. Although in this journal we have not considered interventions to try to reduce the numbers of stillbirths, we are aware of the increasing pressure on women to have induction and ultrasound monitoring late in pregnancy. While these interventions can be life-saving, they also carry risks. We need good research to tell us if and when their use can improve outcomes, and when they may result in more harm than good.

Controversy has also been seen in relation to encouraging women to monitor fetal movement; Gemma McKenzie (page 15) looks at changes in practice, the research, what information women should be given and how their concern about their baby should be addressed. Some research into fetal movements has uncovered a failure to listen to women: our review of Kohner and Henley's book, When a Baby Dies, (page 25) highlights the importance of increased individual care and support.

Attempts to prevent stillbirth can involve promoting interventions that conflict with maintaining normality in pregnancy and birth. Yet continuity of carer offers the potential to improve outcomes and to maintain normality. There are links between stress and adverse outcomes such as IUGR (Intra-Uterine Growth Retardation), prematurity and low birth weight, and there are also links between these problems and stillbirth and neonatal deaths. The significantly lower stillbirth rate achieved by the Albany Midwifery Practice (thealbanymodel.com) suggests a link with excellent midwifery care and continuity of carer and it has been shown that continuity of midwifery carer reduces early fetal loss[1]

We are concerned about the increasing medicalisation of pregnancy and birth in the name of reducing stillbirths and other adverse outcomes. Women are being exposed to more tests, ultrasound scans, inductions and other interventions which often have not been shown to improve outcomes and are not without consequences. We call for more research on the difference continuity of midwifery support can make, an intervention that women want and are campaigning for, and which has been shown to have the potential to improve many outcomes, psychological as well as physical, without doing harm.

References

1. Gardosi J, Kady SM, McGeown I et al (2005) Classification of stillbirth by relevant condition at death (ReCoDe): population based cohort study. BM. doi: 10.1136/bmj.38629.587639.7C
2. Sandall J, Soltani H, Gates S et al (2013) Midwife-led continuity models versus other models of

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