AIMS For a better birth...

Doing things differently

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Rachel Ellman highlights the importance of being heard and supported

This is the story of the birth of my second child at home, and of why that choice was so important to us. It is also the story of how difficult it was to get the support and information that we needed to plan the safest, calmest birth that we could.

My first son was born on the operating table, where I'd been brought after several hours of second stage for a forceps delivery or caesarean section, then left by the surgical team as they were bleeped to yet another emergency. We'd been alone through nearly all 18 hours of violent, chemically-induced labour (all on my back, in unbearable pain, so that the CTG machine would maintain contact – though the team were too busy to monitor or react to it). That moment in theatre was the first time that we had the undivided attention of a midwife: suddenly, my body could work again.

The whole experience left me physically and emotionally debilitated. The hospital Trust told me afterwards that, had I or our son been harmed, they could not have stood by the care we received: it was not safe.

In retrospect, my partner and I realised we'd been too passive in the decisions made about that first birth. When I'd developed obstetric cholestasis (OC) late in my first pregnancy, we meekly followed the hospital's forthright advice and had an induction at 37 weeks. The risks of this procedure, and an understaffed labour ward, were not explained to us, while the (unknown, littleresearched) risks to the baby of going to full term with OC were emphasised.

So, safety was my key motive in planning the birth of my second child: I want to highlight this, because it makes me angry and sad to so often hear home birth described as the risky option. Hippy. Daring. The subtext is that home birth is a choice made by overconfident people, who value their own beliefs or comfort more highly than their child's safety.

I had a list of things we felt were important to a good, safe birth, that I did not have the first time, and it became clear that I was most likely to get them at home: a midwife with me; a labour that began and progressed without chemically-induced violence, and put as little stress as possible on the baby; access to a fast medical response if needed, and to maximise my chance of doing the physical work of labour effectively and without unnecessary suffering by being able (allowed! encouraged, even!) to stand, move around, eat, drink, urinate, stay conscious...

We gathered information, and gained confidence in our plan, through support from our local Positive Birth Group and from AIMS and from our very good GP. At midwife appointments, however, I had to face negative or fearful attitudes towards home birth, and a lack of support finding and interpreting information.

I didn't develop obstetric cholestasis until week 35 of my second pregnancy, so I was entirely healthy when at my first midwife appointment I mentioned that I was considering home birth this time, if it was safe for me and my baby.

The midwife wrote and typed into my notes '*wants home birth against advice*' and refused to remove it the next time I saw her (the only midwife I saw twice in the whole experience). She told me she had '*seen babies die*' when women and GPs '*pushed it*' by avoiding induction with OC. I said how terribly sad it was that these stillbirths had happened, and asked her what evidence she had seen that OC was the cause, and please could I read it, but she had none.

Even GBS was raised as an obstacle to me having a home birth, although I'd tested negative for it in my previous pregnancy.

I tried to book in with a neighbouring borough's dedicated home birth team, but they told me I lived too far away – although I could have given birth in their local hospital.

Eventually, on the advice of the AIMS helpline, I contacted the head of midwifery at my NHS Trust. Things changed then. It was arranged for a senior midwife to sit down with me and make an action plan – for home birth if I was healthy, for blood tests for OC and to meet a consultant to help inform my choice if I developed it.

Finally, at 35 weeks, convinced this baby would come early, I booked in for a home birth. I promised the midwives I'd get something written in my notes from a consultant to say we'd understood the risks, if I did have OC – I didn't want them to feel exposed or stressed when attending the birth, as they clearly would otherwise. Meanwhile, I'd prepared for the birth: for me, planning on having a baby at home meant I felt fully responsible for how this would go. I had planned, exercised, researched, hired a birth pool and essentially trained myself in a way I hadn't the first time round. I felt ready, and calm.

I started to get the OC symptoms that same week, and my liver function tests deteriorated. My partner and I had many re-readings of the OC Greentop Guideline and concluded that still, the safest birth place for us seemed to be at home. We even calculated that we would get faster emergency care if we were transferred in an ambulance (which of course we would agree to) than if we were stuck on a busy labour ward.

At 37 weeks we saw the consultant, who was excellent. We asked him to outline fully the risks for us of both hospital and home, which he did – and he had no concerns about our choice to be at home. He wrote those magic words in our notes. Then he offered me a sweep – which I accepted, as I felt it was better to

have the baby as early as I could before the OC worsened. He found that I was already 2cm dilated.m I walked all the way home from the appointment, pushing my 2-year-old in his buggy. As I hoped, this got the contractions started. Just as I'd visualised, I went properly into labour when my partner came home from work. We called the community midwives at 9pm and our first midwife arrived at 10pm.

The room was quiet, and candlelit. Our 2-year-old was asleep upstairs. I stood throughout labour, leaning on my partner, using hypnobirthing and breathing relaxation as contractions became more intense. All the way through, I felt in control: I was actively doing something – not being 'done to'. In between supporting me through contractions, my partner filled the birth pool. The midwives were a quiet and reassuring presence, but rarely touched me.

There was some pain, as I neared full dilation: but no fear. The baby's heart rate on the Doppler was rather high at first, but in contrast with the fraught response to the CCG in hospital, the midwife suggested I drink lots of water – and his heart rate normalised.

When the second midwife arrived at midnight she did the first examination I'd had, and found me to be fully dilated. I got into the warm pool and my waters broke immediately with a couple of strong surges. Then the next powerful surge – just one – was my baby. He came out in one rush and the midwife said, pick up your baby! I picked him up, held him to me in the warm water and he began to feed, while I relaxed and waited for the cord to stop pulsating. Second stage had been only three surges, and the whole labour only a handful of hours.



Later, I got out of the water and the midwives supported me to deliver the placenta naturally, while our newborn enjoyed skin-to-skin with his dad for the first time.

The next morning, I got up, had a shower and then carried my two-year-old in to joyfully meet his new baby brother. I cannot over-emphasise how empowering and significant this calm, lovely birth has been to me and my family. Not only did it result in a healthy, calm, happy baby and mum: it feels like a redemption of the traumatic experience we had the first time.

I had not realised how important it would be to me to really take responsibility for the birth myself, to do rather than be done to, and to avoid repeating the terrible fear (for my baby, for myself) that went with a loss of control to painful and dangerous medicalised processes that were poorly explained and scantily supported by medical evidence.

Thanks to this birth we have had the best possible start as a family of four. But we had to fight for it. I feel that my experience shows how both mothers and midwives are poorly empowered with the information/training and trust required to do the work they really must be allowed to do themselves, to plan a birth. I only wish that the support and information were available to every woman, to make whatever birth choice is safest and kindest for her and her baby. I salute the work of AIMS, of the Positive Birth movement, and of all professionals within the NHS who are working towards making this a reality.

Following her birth Rachel was invited to share her experiences and thoughts with hospital management in order to better help them support women in the future. The minutes of that meeting are shared below.

Barts Health NHS Trust –Trust Board Meeting Minutes 6 July 2016

The Chief Nurse and Ms Reading, Director of Midwifery, introduced Rachel Warrington who was attending to relate her experiences of maternity services at Barts Health NHS Trust. Ms Warrington had previously shared with the Trust Board her experiences of the difficult circumstances and troubling experiences surrounding the birth of her first child and she had returned to provide details of her experience of the birth of her second child.

Ms Warrington outlined the details of her first birth, which had been complicated by her development of obstetric cholestasis, a condition which affected the liver and resulted in increased bile production. The implications of this condition for pregnancy were not well established but older research material suggested an increased risk of still births. Her extremely difficult labour had resulted in surgical inter vention and her overall experience of the birth of her first child had been one of trauma and feeling disempowered. Ms Warrington had been determined to avoid a similar situation with her second pregnancy and, appreciating her increased risk of developing obstetric cholestasis again, had read widely and actively discussed the options with clinicians. This had included the option to have a home birth, which she had reviewed with her obstetrician, Mr Matthew Hogg, to ensure that this was considered clinically safe and supported.

Ms Warrington provided details of her home birth and contrasted the positive and very personal experience of this when compared with her previous labour, which had been dominated by anxiety. She highlighted potential areas for further improvement, particularly regarding the communication between community midwifery services and hospital clinicians. She indicated that an early consultation with a community midwife had been negative about the home birth option, due to her condition, and that she had documented in the notes that her decision had been 'against advice'. Ms Warrington emphasised that she would not have pursued the home birth option without clear clinical support.

A recurring concern during the pregnancy had been that this midwife would have been subsequently called to attend her birth. She explained that, due to the relatively rare nature of her condition, she had needed to involve senior clinicians regarding whether or not intravenous antibiotics would be necessary (which would have required hospital attendance) and recognised that she had had to pursue this with senior staff (including Ms Reading and Mr Hogg) to ensure that their support was confirmed and documented to ensure that this directed other clinical staff accordingly. Finally she noted the increasing appetite among expectant mothers to consider a home birth and suggested that improvements could be made regarding the organisation of community midwifery services practically and clinically to support this. In particular, she noted the need for better information to support expectant mothers considering this option.

The Director of Midwifery felt that these comments had been extremely valuable and would help to inform the planned Maternity Review, which the Trust had embarked on, and particularly regarding how midwifery services could be more effectively tailored.