AIMS For a better birth...

When mothers know best - The birth of twins

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Helen Shallow reviews the birth stories of two mothers who she supported as a consultant midwife

Introduction

My experience of twin births spans thirty years and, looking back, I see how increasing medical 'management' of twin births has become more focussed on risk and early intervention, and how this has shaped mothers' decision making and experiences. I do not consider myself an expert in twin births and suspect my hands-on experience is fairly average, as twin births do not happen every day in maternity unit:s. Notwithstanding, I have witnessed the birth of unexpected twins, surrogate twins, identical twins, premature twins, caesarean born twins, induced labour twins, post-date born twins, and precipitate term-birth identical twins. Where my area of skill and knowledge comes to the fore is in enabling, advocating for and supporting mothers who make birth choices that don't fit with current guidance or practice. In the spirit of the midwives' oral tradition (Gould, 2017) I would like to share two twin birth stories that occurred in the last five years, before I left the maternity unit to complete my own research journey in 2014.

I have used pseudonyms to protect the mothers' identities, and they gave their permission for their stories to be shared. I write from my perspective as a then-practising consultant midwife. To be clear, I do not take my professional responsibilities lightly. The safety of women and their babies is paramount, and my practice reflects that. A straightforward vaginal birth (if this is the woman's desire) is self evidently the safest option, but of course I have yet to meet a mother who would not be grateful for and accept the advice of a health care provider if she or her baby were identifiably at risk. Safety means reducing interventions which are not required, while recognising those which are, and this works best when there is trust between everyone involved. These two stories are about two mothers who, in essence, wanted to birth their babies themselves, in their own time, and without interventions, unless there was a clear indication otherwise, and with our support. How simple could that be?

Anzu

Anzu is Japanese and lives with her husband and three healthy children. Her first birth was straightforward without complications, and labour was not induced. Expecting twins in her second pregnancy, Anzu expressed the desire not to be induced at 37 weeks. She wanted to birth her babies actively and without interventions. Her midwife referred her to my clinic. As most mothers carrying

twins are under consultant obstetrician care, I rarely met mothers expecting twins in my midwife consultant role. In Anzu's case, her twins were identical and it was evident she was undergoing close observation for any signs of twin to twin transfusion (RCOG, 2016). Anzu talked with confidence about her mothers' twin births and her grandmothers' twin birth and I realised that her motivation was inextricably linked to her cultural-familial heritage. Her family history engendered in her a deeply held confidence and belief in herself, which in effect was translated in to a simple desire to birth her babies herself, unless there was a clear reason to intervene.

My own confidence was bolstered by her self-assured determination. She wanted the opportunity, she wanted our/my support, which was, after all, a simple request.

I met Anzu and her husband several times in the following weeks. In between visits she continued to attend her hospital appointments and had several more scans. On each occasion we were assured that all was well. The babies' growth was parallel and consistent, and Anzu remained healthy on all counts. I set about compiling a birth plan with Anzu and for this I sought guidance from other consultant midwives who had supported mothers successfully toward low intervention twin births.

Knowing the opposition we faced, I was determined that the multidisciplinary team, including supervisors of midwives, should be aware of Anzu's plans for her labour. The simplicity of a 'do it yourself twin birth' is complicated by the possible 'what if' scenarios. Therefore in discussion with Anzu we talked through the possible scenarios in order to have a clear plan a, b and c in place. For example she did not want an IV infusion 'just in case' but accepted it might be needed. So I suggested and she agreed that an infusion would be set up, out of site and easily available. The same applied to a scan for the second twin. The scanner and the doctor were not to be in the birth room, but available, should there be any doubt as to the presentation of the second twin. She wanted to be active and mobile and declined the use of electronic monitoring. In short, each standard recommendation for managed twin birth was put aside, put on standby, and became a safety net, only to be used if needed. Is that not how it should be for all mothers?

Anzu's obstetrician tried to dissuade her, intimating that her birth plan put her babies at risk, but could not say how she was increasing the risks to her babies. Anzu was resolute in her request to give birth unaided, but with support, and this, she argued would not increase the risk to her babies. Anzu's birth plan was communicated to all concerned and we waited in anticipation.

Twin births and best-laid plans

At around 38 weeks Anzu arrived at the maternity unit in advanced labour and gave birth to her first baby in the admission bay. Amidst chaos and panic, the obstetrician was summoned and Anzu's plans for her second twin went unmet as plans were immediately made to transfer Anzu to theatre in case a caesarean was needed for twin 2, however,

"Hold on", the midwife said "I don't think we have time"

"Nonsense," retorted the obstetrician, standing with her back to Anzu,

as Anzu quietly birthed her second baby in to the hands of her husband.

Kelly

I met Kelly in my clinic, again at around 30 weeks, after she expressed a wish to avoid interventions for her twins' births unless they were shown to be necessary. Her added wish was to use the pool. Kelly had one son whose birth was assisted with forceps. Kelly's twins were non-identical and in a good position for normal births. Both twins were head down and growing well. Bolstered with recent experience of supporting Anzu, I felt more confident on this journey, though her request for water birth added a new dimension and challenge.

I was disappointed by the obstetrician's outbursts of indignation and fury at Kelly's 'irresponsible decision-making'. Many midwives also expressed unease. Kelly had undergone assisted conception with both of her pregnancies. For this reason she was considered 'high risk', even though we could not elicit a clear explanation of exactly how this increased her risk, when all her parameters remained normal. When countered with the known risks of induction of labour, this was dismissed as irrelevant. The obstetrician 'washed her hands' of Kelly, even though she was reminded she had a duty of care to all her 'patients'. Therein lies the power struggle between women's agency and medicalhegemony. In effect, Kelly's pregnancy from that point became midwife-led, with myself as the named consultant.

Kelly agreed to a detailed plan of care that we compiled collaboratively, and which included her request to labour and birth in the pool. The plan was communicated to all concerned, so that no one could say they had not been informed. I went on call for Kelly. At the time I lived a two-hour drive away and Kelly was aware I might not make it in time. My colleague, also a consultant midwife, was on standby. There was a clear understanding that one of us would be there to support not only Kelly, but also the midwives. Although they were experienced in facilitating normal births it was clear they needed someone present with the confidence and skill to facilitate twin births in water 'against hospital advice'.

As with all planned hospital twin births, there are two midwives in attendance, one for each baby and invariably the labour ward co-ordinator provides support when the birth is imminent. Also present at a medically managed twin birth, would be the obstetric registrar, the trainee doctor and a neonatologist for the babies. Theatre would be alerted and ready to receive the mother when the births became imminent. At Kelly's birth there were just the midwives and her husband, even though preparations for interventions were discreetly readied in the background and out of sight.

Kelly's water births

Mothers have the ability to let go and give birth at the right time for them, when circumstances allow, which sadly is less evident in modern maternity care. Kelly was 40 weeks when I visited her. She was enormous, tired and unwieldy. I could sense her resolve weakening. She brightened when I told her that, "tonight is a good time to have babies". Her husband would be home after his week of night shifts, and I

was on call and staying close to the hospital. Kelly called me at 2am in the morning to say she thought labour was starting. She sounded relaxed and calm. I told her I would meet her at the hospital. When I arrived soon after, she was already in the pool room wanting to push, leaning on the arms of the two attending midwives. The pool was almost full so we helped Kelly settle in to the warm water.

Kelly's son was born soon after and handed straight to her. Joy filled the room as we waited quietly for the onset of more contractions. As Kelly gave her son his first feed, her contractions resumed. The midwives looked nervous, so I offered to examine Kelly and sure enough her daughter's head was just waiting to emerge. Kelly's daughter slipped into the water and I leaned over and passed her through and up into Kelly's arms. Kelly's daughter was slower to respond, so the midwife passed her to her colleague where, after minimal stimulation, she was reunited with her parents and her brother in the warm pool.

The labour ward was busy that night, and I noted the relief on the registrar's face when we shared the news with her. There was no triumphalism, but there was elation and joy and exhilaration that reverberated round the unit for some time to come.

Conclusion

Why is it, that when women want to birth their babies with our support, with a safety net in place, but without intervention unless it is clearly indicated, why is it so hard to achieve? We are all conspirators. As modern women, as mothers and health professionals, we have unwittingly imbibed the medical risk discourse, that is so hard to shake off, particularly in the labour ward 'just in case' setting. When mothers and midwives work together in partnership and the mother leads the way, we can with confidence support them on their journey. If, as midwives still are, the professional experts for normal pregnancy, labour and birth, midwives can and should support mothers with their requests for a normal birth of twins irrespective of guidelines and protocols. Thank goodness we have them when we need them, but when we do not, let us use our knowledge and skills and respect and trust the mother's judgement that she does know best.

Kelly's Perspective

I became pregnant with my twins following a failed FET and IVF cycle, so began the pregnancy with the knowledge that I would probably never have another. After a fairly traumatic first birth, I knew that I wanted to avoid a second medicalised birth if at all possible. From the outset, I made my wishes clear to the consultancy team at the hospital. At each visit, I would be given the standard information on NICE guidelines for twin births, and I would wearily repeat my preference to avoid unnecessary induction and intervention, to give birth naturally and in the pool. My decision was an informed decision. I read the NICE guidelines for patients and for clinicians. I read medical journals and articles, and heard stories from independent midwives. I spent six years and many thousands of pounds to have a family, and that struggle colours every decision and thought throughout pregnancy - it is never taken for granted and I was hyper-aware of things that could go wrong. So, to be dismissed time and again by the obstetric team providing my care was more than dispiriting. Even with Helen's unwavering support, I still had to fight for the birth I wanted, right up to meeting with the clinical director of the hospital to defend my decision. I'm

sure many people would have given up by then, cowed by the system that supposedly exists to care for them. In the event, I gave birth to two extremely healthy babies, on my due date, and returned home the same day as a complete family. My beautiful, positive birth experience is testament to the fact that no women should be subject to a "one size fits all" approach to labour and birth, discounting the instincts and experience of midwives and mothers.

References

Gould, J. (2017) Storytelling in midwifery: Is it time to value our oral tradition. British Journal of Midwifery. Vol.25(1), pp.41-50.

RCOG (2016) Guidlne 51: Management of Monchorionic Twin Pregnancy.

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[1] Identical twins otherwise known as monozygotic twins are distinct from non identical twins in that they have developed from the same egg. Monochorionic, also identical twins, may share the same amniotic sac and placenta and this increases the risk of twin-to-twin transfusion, which can be life threatening for one of the twins who may fail to thrive.