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Birthing twins – encouraging normal physiology

By Chris Warrren

'*You need a maternal-fetal specialist, an obstetrician, who has received specialist training and put it to use in the management of high risk pregnancies*' (Luke and Eberlein 2004[1]).

This strongly worded advice to parents expecting more than one baby reflects the view of most prospective parents and healthcare providers, but not all. Women expecting twins and who book with independent midwives disagree. Women pregnant with multiples are no more a homogenous group than women who book for independent care but who are carrying one baby. They have different reasons for choosing an independent midwife, but most want to minimise medicalisation and avoid 'routine' interventions during their pregnancy and births. This article is based around the births of four sets of twins supported by Yorkshire Storks, but a couple of others have crept in. All of the women's names are pseudonyms, unless they have expressed a desire to own their own name, and all have given their permission for their stories to be included.

Jessica booked with us at 28 weeks after being told by the community midwifery manager that she could not have a home birth as she was expecting a big baby and her midwives were scared of having to deal with a shoulder dystocia. Two weeks later I realised Jessica was carrying twins. I had missed them the first time I palpated her abdomen. She still wanted her home birth.

Nora knew from an early scan that she was expecting twins. She was happy to access the hospital for scans and initially she felt comfortable seeing the obstetrician, but wanted the convenience of antenatal care at home at times convenient to her work commitments. She knew that she did not want to be 'messed about with'. She wanted to avoid vaginal examinations, induction, continuous monitoring and imposed time limits and wanted ideally to birth at home. She wanted to minimise interventions.

Lindsey does not like being told what to do and not being listened to and she quickly realised during her antenatal care that she wanted and needed to be supported in her informed decisions and therefore booked with us. She is not a nurse but works for the NHS.

Hayley wanted a home birth with her IVF twins, had had a traumatic birth of her first, and a home birth with NHS midwives for her second but had not felt well supported. She knew that her community

midwives would not be comfortable at a home birth with twins. She is a nurse working within the NHS. One of her friends had booked with us to minimise medical interactions as she was considered high risk for other reasons – so we came personally recommended.

These four women were expecting diamniotic-dichorionic (di-di) twin babies: each baby had their own placenta and amniotic sac and was not at risk of having a twin-to-twin transfusion – a potential risk when the babies share a placenta, where one twin thrives at the expense of the other[link to Rebecca's article]. All the women were offered, and some took up the offer of, regular growth scans, a good way of picking up this problem, despite it not being a reality for any of them. Jessica had decided not to have any scans but accepted one to 'confirm' my findings that there were two babies, and to find out what 'sort of twins' she was carrying. This would influence the discussion we would have about the likelihood of problems occurring. Nora had fourteen scans and found them reassuring despite the babies sometimes measuring 'too big or too small'. Lindsey had five scans and declined several. My client notes state *'does not want a scan as then she will have to see the consultant who will go over everything again'*.

It is difficult to get good evidence of the likelihood of problems as the research tends to consider all sorts of twins together, but there is acknowledgement that di-di twins are the most straightforward. NICE (2011) in its Twins and Triplets Guideline[2] says that '*The evidence relating to such pregnancies was very limited in quantity and quality*'. The Guideline does list many increased problems for those expecting multiples but also acknowledges that *'An awareness of the increased risks may also have a significant psychosocial and economic impact on women and their families because this might increase anxiety in the women, resulting in an increased need for psychological support*'.

This increased anxiety increases the likelihood of the women accepting an unwanted intervention as their confidence in themselves and belief in the ability of their bodies to birth their babies have been seriously undermined. These interventions could have unexpected consequences and increase harms.

The chance of a woman carrying twins developing pre-eclampsia, obstetric cholestasis or going into pre-term labour is higher, but how much higher is difficult to ascertain. None of 15 sets of twins that have booked with us have been born before 37 weeks, with most going to 39+ weeks and Hester's babies being born at 41 weeks and 3 days. One of our twin clients had signs of pre-eclampsia and possible obstetric cholestasis at 38+ weeks and had reluctantly agreed to go in for an induction, but, the night before, went into labour and birthed her babies spontaneously and straightforwardly in hospital. The second twin was born after a 4-hour gap just before the consultant who had tried to bully our client was due to make her ward round.

Another factor frequently given as a reason for home being less safe than hospital for birthing twins is the increased chance of the woman having a significantly heavy bleed after the babies are born. The logic for this is that there is a bigger placental area to bleed from and that the uterus has been overstretched and therefore will not work so well after the birth. This has not been an issue for us where the labours have been spontaneous and the births straightforward. The physiology of the control of bleeding from the placental site is that when the uterus is empty and contracts to become smaller, the muscle fibres of

the uterus act as 'living ligatures' to squeeze and (mostly) close the blood vessels. This seems to work well when labour and the immediate post birth time is not disturbed. Active management of the third stage of labour, the birth of the placenta and membranes, after giving an intramuscular injection of a synthetic oxytocic drug, is advised by NICE and all the NHS policies I have seen, but in my experience as long as the atmosphere is calm the placentas will birth spontaneously without interference. Eight out of ten top tips for a physiological third stage focus on maintaining the quiet, peaceful atmosphere, the baby nuzzling at the breast and no interruptions.[3]

Independent midwives working in Yorkshire benefit from collaboration with Airedale NHS Trust and are legally able to provide birth care for our clients. We now share the Airedale guidelines with our clients, even though there are several pages of risks to mother and baby that are not contextualised or explained in the best way. The guidelines allow for clinical judgement but make it clear that deviating from the guideline must be explained and documented. Risk is a contentious issue and those involved in making decisions on where and how to birth their twins need to be aware of the medical concerns, the evidence, the robustness (or otherwise) of the quoted 'facts' and that these figures come from population studies and need to be individualised and put into context for each woman. The language used to express risk carries emphasis and value judgements and supports the idea that pregnancy inherently needs medical help. The term 'risk' '*evokes feelings and concerns to such an extent that it is accepted in a critical way that helps determine the delivery of maternity care*' (Thompson 2002[4]) and '*Women are subject to a litany of risks regarding birth [even with a singleton – my insertion], resulting in perceptions of risks that are not always rational* ' (Healy et al. 2016[5]).

Our twin clients who choose to birth at home do so in the well-researched belief that this is the safest and best option for their babies. They reject the medical model of birth and the medicalisation of pregnancy and birth, and do not necessarily accept all medical opinions, especially when these differ from information they have found for themselves. They are affected by 'shroud waving' and negative medical opinion, especially when it is said time and time again. They often feel that they have to justify their decisions to each new healthcare provider (even though in fact they do not need to justify their decisions to anyone), they face disbelief, the information they have found is dismissed and fears are raised without references or acceptable justification. Repeated discussions focussing on what can or will go wrong may have a nocebo effect of increasing the likelihood of problems occurring (Symon et al. 2015[6]). Once we find a consultant midwife or obstetrician who understands informed decision-making, we stick with them like glue. All of our clients willingly accept medical help when it is necessary for them or their babies' well-being.

Many of our clients are affected by the 'climate of fear' within maternity care and we need to help them unpick the issues and see risks in context to themselves. Jessica's waters released at 34+ weeks and found she had Group B Streptococcus (GBS) colonising her vagina. About a third of women harbour GBS at any one time and only rarely does it cause complications, but when it does the consequences can be severe and in rare cases can result in the baby or babies dying. Jessica did a lot of reading about the subject, and took her temperature as suggested. After seeing her consultant – a very reasonable doctor

who understands not to coerce women – she then only saw us and birthed her twins at home, 37+ weeks and before her partner could fill the pool. She reports her experiences in more depth in this edition of the AIMS journal (Hind 2009[7]).

Nora decided after seeing her consultant a couple of times not to see him again, but just to have the scans. This caused her local Trust concerns and we spent a lot of time liaising with the Supervisor of Midwives to reassure everyone that Nora was making reasonable choices that were safe for her and her babies and that she was accessing midwifery care. Lindsey, likewise, minimised her interactions with consultants after seeing them twice and receiving a perceived aggressive letter rejecting her decisions, but she did access the maternity unit on several occasions when she became concerned about her babies' movements. She did not reject the whole NHS system, but just the aspects that she did not find helpful.

Lee *et al*. (reference 8) found that women had different strategies to avoid confrontation with obstetricians or midwives who gave advice or information they perceived as biased or unhelpful. The article found that, sometimes, women decide to disengage or to lie. The authors suggest time during consultations should be used '*to explore women's feelings and beliefs to gain better understanding of their motives and choices*'. At a 'Policing Pregnancy' conference looking at risk and choice in maternal autonomy, the speakers agreed that we need to trust women and that they will nearly always act in their babies' best interest and '*it may be counterproductive for policies to tell them how to do so*' (Murphy 2016[9]). Our clients booked with independent midwives to have more time, to be listened to, to be respected, to be sensitively challenged and then supported in their decisions. There is also, usually, an overlap of shared philosophies around birth, a belief that given the right circumstances women's bodies nearly always work well to birth their babies.

Risk assessment was introduced to target those women considered to be more likely to have problems and to need interventions to keep them and their baby safe, but it has led to '*pregnancies fraught with worry, an ever increasing fear of labour and birth, and a reluctance of women to make choices that reflect putting risk in perspective and deciding for themselves what an "acceptable" risk is*' (Lothian 2012[10]). The author of this paper, a childbirth educator, goes on to say, '*It is important that we spend time discussing the differences between risk and safety and making it clear that the current maternity care system increases risk and makes birth less safe for mothers and babies*'.

For our clients, avoiding medicalisation of birth includes accessing certain aspects of care provided and saying 'No, thank you' to others. Many healthcare providers have difficulties with this, probably because they feel threatened when women disagree with their view or the policy. This may be because they feel responsible and don't understand autonomy in childbirth (Prochaska 2013[11]). Equally, working within a system where blame culture is endemic and there is a high fear of litigation, it is not '*surprising that risk-based care takes precedence over considerate individual care*' (Healy et al. 2016[5]).

Hayley was lucky enough to meet an obstetrician who said that he respected her choices and understood that as long as she had capacity, and he could see from the information she provided him with that she did, she was within her rights to choose her place of birth. That interaction was positive enough to make

transferring in with the second twin when we had concerns over his rising heart rate far more acceptable than if all the hospital interactions had been negative and adversarial. The second twin was born spontaneously after an ARM as the staff were preparing for a caesarean due to their concerns over the time elapsed since the first babe was born – about four hours. Both are thriving.

Informed decision-making results when women (and families) have access to reliable information, and they can explore how this impacts on them and they feel supported. Women should not have to fight to avoid medicalisation and unwarranted interventions. Even with the support of a senior, very experienced midwife, Karen still felt she had to fight the system. (*See "When mothers know best" by Helen Shallow in this journal*[12].)

There is good evidence that fear adversely affects the physiology of birth and it follows that interventions aimed at the 'just in case' scenario can influence what happens. Also, the usual hospital 'management' of twins may well contribute to the problems that then occur. For instance, an epidural is advised in case an urgent caesarean is needed if the second twin becomes lodged in a transverse position after the first is born, despite the fact that this leaves the woman on her back (unless supported to be upright) and this can itself cause the baby to lie transversely. When the woman is actively labouring, and upright after the birth of the first baby, gravity is likely to help the second baby to a longitudinal position, head or bottom first, minimising the need for a caesarean. But if a woman is supine, it is more likely that the second twin will assume a transverse position and then need help to exit the womb. Jo Whistler (2011)[13], writing for this journal, eloquently explores further the ways the NHS proposed management of the birth of her twins could increase the likelihood of complications. She chose independent care and birthed her twins in water on her canal boat.

The NHS's strict time limits with regard to when the second twin should be born just don't fit with our lived experience, and seem illogical. I believe vaginal examination should never be offered as routine but only if the clinical situation suggests that the findings could be useful to help decide on the next course of action, for instance if palpation or just observation of the uterus indicates that the second baby appears to be in a transverse position. During my very first experience of twins born in water, the mum suckled her new born and had lunch, we topped up the pool, she suckled her toddler and then her new born again, and then her contractions restarted. It was so normal and straightforward. She had no vaginal examinations but we did listen in to the baby's heart rate. She suckled both and then got out to birth the placentas. I learnt a lot from that woman. She did it her way in her own time and listened to her body and responded. She did feel supported – it was a long time ago and I knew no better than I should support the woman in her informed decision-making – I had no fear so did not communicate that.

Respect for physiology is important in the way independent midwives (and those NHS midwives striving to maintain and promote normal/natural/ physiological birth) support women. Foureur (2008)[14], writing about creating safe spaces to promote and enable undisturbed births to unfold, explains that reducing stress and creating a calm environment allows the oxytocin mediation of the neural-hormonal system to work properly. This needs psychological and social awareness of the woman and family from the midwife

as well as awareness of optimal birthing environments. Knowing your midwife, her knowing you, feeling cared for and supported are as important as the environmental factors: calm, quiet (or the woman's choice of loud music), low lighting and no intrusive tests or examinations. The more we learn of the physiology of labour and birth and how the emotions and hormones interact, the better we can support instinctive birthing. '*Ensuring women maximise the limbic brain connection is about supporting them to "disconnect" with others during labour whilst also maintaining the usual physical and emotional midwifery care*' (Dixon et al. 2013[15]).

In a series on 'Midwifery' in the Lancet, which took a global view of midwifery care, the core characteristics of midwifery were identified as '*optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families*' (Renfrew et al. 2014[16]). The current organisation of maternity care prevents midwives from fulfilling this role. The medical model has all but taken over. There is increasing concern that while childbirth has never been safer, fear of litigation is driving care towards routine interventions that potentially result in harms to women and babies.

With our four sets of twins, the babies were born 3 minutes apart, 5 days apart [!], 30 minutes apart and 5 hours apart and sometimes the placentas took their time. And it was OK. In two cases the second twin was born in hospital, one spontaneously vaginally after an ARM and the other by Caesarean, and all were well.

Reflections

Renfrew et al. (2014)16 consider "*there is global concern about the over use of treatments that were originally designed to manage complications, with the consequence that many healthy women and newborns in high-income, middle-income and low-income countries are being exposed to the adverse effects of unnecessary interventions being used routinely*". I agree, and this applies even more to twins than to singletons.

We need to know more to ensure we 'do no harm' to both mother and baby/babies. Being quietly in the background, making tea, topping up the pool, ensuring phones are on silent can be positive things we do. It makes sense not to intervene unless we and the woman can weigh up the potential benefits and harms of the intervention. Listening to women, learning from them and respecting their decisions are equally positive contributions to creating a safe birthing environment.

This article is written from my point of view and I have worked independently since my daughter Jess was born (at home with the NHS) 28 years ago, but I would work in the NHS again if it fully supported continuity of carer and women's choice. I have been lucky to have had the opportunity to learn from the women I have supported and from their belief in their abilities to birth their babies. This has allowed my belief in psychophysiology to develop.

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