AIMS For a better birth...

Natural VBAC in Ireland - A Real Miracle Birth

By Juliet Stephenson and Jane Wright

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It can be difficult to get a normal birth in Northern Irish hospitals and a normal Irish VBAC is almost unheard of. As the following story, shows, however, it is not impossible.

The maternity unit of the Erne Hospital in Enniskillen, Co. Fermanagh (part of the Sperrin Lakeland Trust) has a long-standing reputation for having a high rate of induced labours. For many years most women were persuaded to have their labours induced at 38 weeks, on a Tuesday or Thursday. In the early 1990's I asked the Chief Executive of the Sperrin Lakeland Trust if he was content with this and he agreed that 'it didn't look good'. They had therefore tried to spread the inductions over Monday to Friday.

When a unit has a long history of interventionist birth practices it is particularly good to hear from women who have had good birth experiences and examine the factors, which assisted them to achieve this. The following account from Julie Stephenson is one such story.

Julie is a teacher and in 1999, at the age of 39, she became pregnant with her first child. Having read a lot, discussed her options with her sister Jane (who was and is a La Leche League leader), getting in touch with AIMS and attending NCT childbirth classes, Julie decided she wanted a homebirth as this seemed to be the safest least interventionist option. Apart from a heavy bleed at 6 weeks every thing seemed to go well until Julie was 7 months pregnant.

At first Julie did not think anything was unusual about the midwife carrying out repeated foetal length measurements or that the sac was being described as 'loose'. However the midwife felt there was insufficient growth and on her advice Julie took 2 weeks off work and had a third scan which revealed a baby of average size with all other results normal. Then the midwife that was caring for Julie went on sick leave and from this point in time Julie felt that there was poor continuity of care from the community midwifery service, which got caught up with trying to prevent a home birth rather than emphasising excellent antenatal care.

Retrospectively Julie feels that there were signs of the pregnancy failing to thrive from 7 months but with a good scan result she was lured into a false sense of security. Better advice at this time would have enabled her to leave work sooner. Other things, which might have made a difference, were better continuity of care and, perhaps, an additional scan (she had been trying to minimise the number of repeated foetal ultrasound scans owing to concerns about their safety).

Two days before Julie's due date, a scan showed the baby to be small, unresponsive, and with a poor

blood supply and the placenta heavily calcified. A caesarean section was booked for the following day. The sudden change of events left Julie and her husband Joe with a profound sense of shock. At home they tried to come to terms with what they had been told.

The following day Julie gave birth to Jasmine Joy a healthy 4lb 13oz baby whose only problem was that she wanted to be fed. Joe stayed overnight on the day of Jasmine's birth to help Julie with breast-feeding Jasmine. Although the midwives were content with Julie's recovery, she felt her progress was slow.

Feeding at night and even holding the baby was difficult. Julie was extremely tired and sustained several minor injuries and lower back pain during this period as she tried to cope with a new baby and the after effects of the section. Breastfeeding was also difficult but the support of her sister Jane at home was invaluable.

Bt Christmas 2000 Julie felt fully recovered and at the age of 41, going on 42 decided it was time to try for a second baby. During the second pregnancy (due date 6th January 2002) Julie suffered a number of relatively minor problems during her first two trimesters. Morning sickness, a bleed at six weeks, a long chest infection and sinusitis, were all troublesome but the pregnancy itself did well. On medical advice and in the attempt to avoid a repeat caesarean, Julie left work 7½ weeks before her due date.

Julie wanted as natural birth as possible, but was depressed about the possibility of getting this. Although she had read extensively during her first pregnancy, she felt she had to force herself to read this time and was finding it difficult to be positive about the birth. She spoke to her sister Jane in Canada about her feelings and Jane said she would come home for a second time to give her support. Instantly, Julie felt better! When Julie tells her story she stresses this point. She says it really was instant. Before she got off the phone she felt much more positive.

Jane arrived on the 31st of December 2002. Julie still had no birth plan and was beginning to feel pressured by obstetricians at the Erne to have her birth induced. The arrival of Jane, gave Julie and Joe much of the support they needed to write a birth plan. Jane contacted friends and midwives in Canada and Julie contacted AIMS.

The whole family became rapidly expert in VBAC and induction following caesarean section. Some in-depth conversation with Julie's Community Midwife also helped her to understand the obstetric philosophy of the Erne Hospital. One friend was of particular use, she was the only member of Julie's circle of friends to have had a birth without interventions in the Erne.

Perhaps this was partly due to the fact that she was a knowledgeable professional with a forceful nature. Her advice to Julie was to 'keep away from the obstetricians and trust the midwives'. Julie avoided talking to other women who had ended up with inductions, sections, forceps and ventouse deliveries.

Five days after Julie's due date her obstetrician suggested a prostaglandin induction. Julie refused. At this stage although she was attending the antenatal clinic every two or three days for scans, she sometimes had to cancel an appointment, which appeared to disconcert staff immensely. At one

appointment Julie ended up waiting two hours with other stressed out women and she began to feel more harm than good was served by this experience.

She refused an internal examination by a house officer and was then subjected to a lecture by an obstetrician who told her that he 'had given her his advice' and that if she failed to obey him she must understand that she would be responsible for the birth. Julie says that her jaw dropped and she nearly laughed. Why is it assumed that pregnant women abdicate responsibility for their birth to strangers and then assume it again afterwards?

Each scan had shown good blood flow and foetal heart rate and a baby developing normally. Julie told the obstetrician that she would decide what care would be accepted on the basis of her scans and reviews. On medical advice she also attended the maternity ward for additional monitoring. This was useful as she got to know one or two midwives on the ward.

When Julie was 9 days passed her due date she encountered a female house officer who was extremely rude to her. Julie had come across this individual before and had noted her appalling rudeness towards the midwifery staff. When Julie asked the staff if this was normal behaviour for this doctor, they responded that it was, but they tried to ignore it. This officer was determined to browbeat Julie and told her she must accept a prostaglandin induction.

Although shocked by the house officer's behaviour Julie said that she 'accepted nothing'. She asked the house officer to accept that they had 'different opinions'. The house officer stalked out.

An internal examination shortly after the house officer left, showed Julie to be slightly effaced. She gave the midwives her birth plan, which on request they put in her notes. At this point Julie began to feel that she and her family were better informed on the risks and benefits of prostaglandin inductions and VBACs than the medical staff.

It's hard to explain how difficult it was for Julie to maintain confidence in her ability to give birth when she had no experience of normal birth and knew few others who could, from personal experience, reassure her that a natural birth would be possible, much less get reassurance of a natural birth following a caesarean.

Julie was prepared to go to 14 days over her due date before considering other options but at + 11days she went into labour during the night. She began, with Joe and Jane's help, to make preparations. Julie did not want to go to the Erne too soon so she left it for as long as she could. By 1pm her contractions were 5-10 minutes apart (her 10 year old nephew was given responsibility for timing these!) and Julie felt if she left it much longer she wouldn't be able to manage the journey into town.

On arrival in the Erne, at 3pm, Julie was disappointed to find that she was only 1½ cm dilated. The midwife present read through the birth plan and said it was fine. She said it was rather like a home birth plan, which she felt comfortable with and had experience of in a previous job. After an examination Julie, Joe and Jane were allowed to settle in a little room at the end of the ward.

Shortly afterwards Julie passed the plug of mucous that normally covers the cervix - a sign that labour was beginning. She found a bath and several showers tremendously relaxing, during the next few hours, and laboured standing, supported by Joe and Jane, eventually lowering into a squatting position. By 5pm Julie had reached 10cm and her contractions felt strong. Her waters broke sometime after this. Fresh meconium was present but the midwife said this was normal for an overdue baby, and that it did not present a problem.

Labour only felt difficult during three uncontrolled contractions when Julie hadn't time to get into position following examinations. Julie did not have any intravenous fluids, no monitor and took sips of fruit juice from time to time. Hot compresses on her perineum were also very useful (although the midwives had never heard of them, they were very willing to use them). A Doppler was used throughout labour to monitor the baby's heart.

Julie was three and a half hours in the second stage and had to do a lot of pushing at the end. She gave birth kneeling into a beanbag with her midwife on the floor and a second midwife massaging the first's back. Julie felt very comfortable with her midwife. Earlier she had asked her if she was 'past the point where a section could be done' (not realising that a section can be done at any point). The midwife wisely responded by side stepping the accurate reply.

By 8pm the midwife was due to go off duty. Her husband was waiting at home with the children, and had to go to work, but although the night staff had come on duty she chose to stay with Julie. Julie felt a strong bond of trust with this midwife. She therefore feels a huge debt of gratitude to that midwife who stayed and went the extra mile.

Patrick was born quickly at the end. At 9pm after crowning his head and shoulders came with one contraction. Julie had a little grazing but no tearing. The placenta was delivered naturally a few minutes later.

After giving birth Julie enjoyed a hot bath, the midwife running water over her tummy, which she describes as wonderful. She asked for the cot sides to be put up on her bed and padded them with pillows so she and Patrick could sleep together in the bed. Joe slept on the floor as he had done when Jasmine was born. Julie says she has never felt as happy as she did that night (Jane went home at 1am after giving Julie home-made honey, lemon and ginger tea).

Julie went home two days later. She had less support at home compared to her first birth, but she felt she didn't need the same level of support. She describes her feeling following Patrick's birth as being 'elated for a long time'. In retrospect her first birth had left her with a feeling of 'having failed' but her second

birth gave her a 'tremendous sense of power'. She felt she could cope in a way she couldn't after Jasmine's birth. Breastfeeding was also much easier.

A successful natural birth for Patrick was not easily achieved. Waiting to go into labour was very stressful. Researching into VBAC and inductions and for Joe, Jane and Julie learning to operate as a closely knit and unified team to face the professional opposition, was a lot of hard work.

During her labour one of the midwives commented that a sister-in-law, with a previous section would shortly be having a baby. She hoped she would be as lucky as Julie. But according to Julie, Patrick's wonderful birth was not due to luck. It was due to a lot of hard work, to the wonderful support of Jane, to some wonderful midwives and to an old 42-year-old female body that knew how to do its job if left to it.

Julie concludes; "Both my babies are wonderful. Jasmine Joy is special because she clung to life with a determined and tenacious spirit. Patrick Thomas slipped into the world alert and relaxed and responds to everything with laughter and joy. I strongly believe that our birth stories underline the need for good midwifery care during pregnancy and birth. For obstetricians and doctors to be brought into the picture only when a medical problem occurs rather than be used routinely."

Julie Stephenson
Jane Wright

Julie's Birth Plan

We are looking forward to giving birth to our second baby at the Erne. The birth of our now two-year-old daughter Jasmine was by a planned caesarean section in this hospital. We were very happy with the excellent care that we received. This time we are planning a VBAC. We realise that every birth is different and that a VBAC requires some special considerations. In our desire to have the happiest and most memorable experience possible we have listed our birth preferences below. These decisions have been made after much research and thought. Therefore your help in attaining these goals is very much appreciated. You can be assured that in the unlikely event of complications, our full co- operation will be rendered after an informed discussion with the doctor has taken place, and adequate time for private consideration has been given to us.

Objectives

- To achieve a spontaneous labour
- To have a natural, intervention free labour and birth of baby and placenta
- Midwifery care only, which is both supportive of, and experienced in VBAC
- To be supported throughout labour by birthing partners; Joe (husband) and Jane (sister)

On arrival

- Stage of labour diagnosed
- If early, return home or use of amenity room with access to shower

- Please no IV or Heparin block

First-Stage Labour

Monitoring

- Fetal heart rate (FHR) monitored by fetoscope or handheld Doppler is preferred to electronic fetal monitoring
- Intermittent electronic fetal monitoring is OK; no internal fetal monitoring please

Methods of pain control

- Warm bath / shower
- Cold / hot packs to head and back
- Freedom to change position, walk about and use of birthing ball
- Massage, use of almond, rosemary and lavender oil
- TENS machine
- Gas and air
- Music

Other considerations

- Drink and eat as required for energy and hydration
- Vaginal examinations only upon consent, as few and as gently as possible to avoid premature rupture of membranes
- Freedom from time constraints (such as Friedman's 1cm per hour) providing mother and baby are doing well. (Also applicable to entire labour and birth.)
- Quiet room, no excess hospital staff please. (Also applicable to entire labour and birth)

Second-stage labour

- Choice of positions for pushing, no stirrups please
- Mother-directed instinctive pushing is desired rather than coach-directed
- Perineal massage, hot compresses, controlled pushing rather than episiotomy

Third-stage

- Please place baby on mother's abdomen
- Cord not to be cut until pulsing has stopped
- Baby to breastfeed immediately to assist in natural delivery of placenta. No pitocin [syntometrine], uterine massage, or pulling on the cord please

Post partum

- No exam of uterine scar
- If heavy bleeding occurs, no blood products, unless situation has gone beyond borderline. We are very worried about receiving donated blood
- Baby is to receive only breast milk, no supplementation please
- No vitamin K injection for baby
- Joe to stay overnight with mother and baby

In case a caesarean becomes necessary

- Joe and Jane to be present during the preparation, and during the operation, if desired
- Jane to stay with mother after the birth while Joe stays with and, as much as possible, holds the baby
- Parents allowed the option of viewing the birth (possibly by lowering the screen)
- If a general anaesthesia becomes necessary, father to remain during the birth in order to greet the baby

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