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'High Risk' When does a label become a self-fulfilling prophecy?

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Cover Picture: Joanne Whistler labours at home with twins see page 22 ©Paul Mann 2011

Invitations have recently gone out to AIMS members inviting them to join the AIMS Members Yahoo Group. If you are not already on the group and have not received an invitation, this probably means that we do not have an up-to-date email address for you. If you would like to update your email address on our database, please email membership@aims.org.uk including your postcode.

Being a member of the group will not only allow you to have contact with other AIMS members and to hear what the current issues are for them, but also will allow the committee to keep you up to date with what we are doing, when and where the next meetings are planned to take place and what you may be able to do to support AIMS.

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Is the 'high risk' label helpful?

Vicki Williams asks us to question the notion of treating simply on the basis of 'risk'

Reading through the copy for this issue, I have to ask myself, is this label of 'high risk pregnancy' doing women any favours, or is it frequently actually creating damaging additional stress for childbearing women and those who care for them?

It is becoming increasingly clear that, for some women, knowing that they have additional risk factors helps to inform their decisions for pregnancy and birth, but for many others it seems to be a label that creates its own fear and risk purely from the reactions of women and their care teams to it. As the title of this issue suggests, this perception of an increase in risk may serve only to make it more likely that a woman will have unnecessary and unwanted intervention in her pregnancy and birth.

It is important to acknowledge that some women or their babies may have health issues that lead to difficulties, but most labelled as 'high risk' could go on to have completely straightforward births. It is vital that excellent medical care is available for situations when it is needed, as identified in the Confidential Enquiries into maternal and child health; however, until such medical care is actually required, women need to be supported and encouraged to have normal births, with watchful awareness of potential problems, just as should be the case for 'low-risk' women.

This issue of the AIMS Journal has only scratched the surface. It takes a brief look at the concept of safe and undisturbed birth in Sarah Buckely's article on page 4, which gives some background on how we can often make birth more risky simply by trying to control it or offer 'help'. Birth in high-income, litigation-driven countries has often become so fraught with danger of our own making that great efforts are made to intervene in order to save women and babies from iatrogenic [caused by medicine] effects. What is needed is a move towards preventing the danger in the first place by providing environments that support undisturbed birth and midwifery care for all women whatever their obstetric status. Currently the medical model focuses on risk, a focus sadly perpetuated by the majority, professionals and laypeople alike.

Just like all mammals, we need to be physically ready for pregnancy. We need to be well nourished and safe during the time we are growing our babies, and we need to feel safe, calm and protected whilst we birth our babies. It is really not hard to achieve, except that we have built a culture of fear round birth which gets in the way of the process and creates extreme danger for us and for our babies during pregnancy, the birth and the bonding period. I have noticed a real disparity between texts which look at facilitating safe mammalian birth and those which focus purely on human obstetrics. The effects of birth disturbance can create a whole range of problems, including physical damage, disrupted bonding and extreme trauma responses.

A series of articles look at the complex issues around obesity, looking not only at the evidence, sketchy at best, supporting the concept that larger women are always and automatically bound to have complications, but also at how women themselves view the care they receive and the labels that so often go alongside a high weight-to-height ratio. It came as no real surprise to me to see that unbalanced nutrition goes hand in hand as often with obese as with under-weight women, and that both can have serious implications for a growing baby. However, the notion that women can have a high BMI and be well nourished and healthy is one that the current government targets on tackling obesity seem to have neglected to mention.

The issue of meconium is tackled by Sarah Davies on page 17. It is something that seems to be feared by birth professionals and women alike, but again the evidence does not seem to suggest any reason for that fear or for the interventions deemed necessary when a baby has opened his bowels before birth. This might be one of those areas where treatment creates many more problems than it prevents; it certainly creates a considerable increase in stress and disturbance.

The selection of birth stories for this issue was very difficult, from the many, many stories we hear of women who have been deemed high risk but have gone on to have beautifully empowering normal births. We chose to share the home birth stories of a breech birth, a twin birth and a post-dates pregnancy. Sadly, with standard care those women may have been encouraged to accept caesarean surgery or induction, but in fact they went on to have births which left them feeling powerful and ready to start their journey to parenthood. All of those parents did a great deal of research into how the risks they were facing applied to them, and they made decisions and gathered their care teams accordingly. Many women simply do not get that chance, for more reasons than we can cover in this journal. Some of these women would have preferred to have the opportunity to birth undisturbed in a hospital setting but were denied that option.

The omissions in the Journal seem glaring. We have not considered VBAC, suspected small or large babies, women with high blood pressure or a diagnosis of gestational diabetes. The list goes on and on and many issues of our Journal could be filled with teasing out the evidence that supports the concept of risk in those situations. However, for unnecessary harms to be avoided we all need to acknowledge that a risk label usually means a shift from a 'tiny risk' to a 'very small risk' of an adverse outcome. That means the chance of everything being normal is still very high. What women want is not a label, but individualised care.

Vicki Williams

Undisturbed birth

Sarah Buckley shows us what is stopping birth working

In modern Western countries, including Australia and the UK, rates of obstetric intervention have reached extreme levels, such that very few mothers and babies experience labour and birth without drugs and procedures to assist or hasten the process. This has led to the erroneous belief that human birth is an intrinsically faulty system, and that modern women have lost the ability to give birth.

However, our women's bodies have their own wisdom, and our innate system of birth, refined over one hundred thousand generations, is not so easily overpowered. This system, which I am calling undisturbed birth[1], has the evolutionary stamp of approval not only because it is safe and efficient for the vast majority of mothers and babies, but also because it incorporates our hormonal blueprint for ecstasy in birth. When birth is undisturbed, our birthing hormones can take us into ecstasy – outside (ec) our usual state (stasis) – so that we enter motherhood awakened and transformed. This is not just a good feeling; the post-birth hormones that suffuse the brains of a new mother and her baby also catalyse profound neurological changes. These changes give the new mother personal empowerment, physical strength, and an intuitive sense of her baby's needs, and they prepare both partners for the pleasurable mutual dependency that will ensure a mother's care and protection and her baby's survival.

her baby's safety is also enhanced, not only during labour and birth, but also in the critical postnatal transition

Undisturbed birth represents the smoothest hormonal orchestration of the birth process, and therefore the easiest transition possible; physiologically, hormonally, psychologically, and emotionally, from pregnancy and birth to new motherhood and lactation, for each woman. When a mother's hormonal orchestration is undisturbed, her baby's safety is also enhanced, not only during labour and birth, but also in the critical postnatal transition from womb to world. Furthermore, the optimal expression of a woman's motherhood hormones, including the fierce protectiveness of her young, will ensure that her growing child is protected and well nurtured, adding another layer of evolutionary fitness to the process of undisturbed birth.

The hormones of birth

There are many hormones involved in mammalian birth, and our understanding of their complex orchestration is limited. This article focuses on the hormones oxytocin; beta-endorphin; the catecholamines (adrenaline and noradrenaline); and prolactin. As the hormones of love, pleasure and transcendence, excitement, and tender mothering, respectively, these form the major components of an ecstatic cocktail of hormones that nature prescribes to aid birthing mothers of all mammalian species.

An optimal hormonal orchestration provides ease, pleasure, and safety during this time for mother and baby. Conversely, interference with this process will disrupt this delicate hormonal orchestration, making birth more difficult and painful, and potentially less safe.

All of these hormones are produced primarily in the middle or mammalian brain, also called the limbic system or emotional brain. For birth to proceed optimally, this more primitive part of the brain needs to take precedence over our neocortex – our 'new' or higher brain – which is the seat of our rational mind. This shift in consciousness, which some have called 'going to another planet', is aided by (and also aids) the release of birthing hormones such as beta-endorphin, and is inhibited by circumstances that increase alertness, such as bright lighting, conversation, and expectations of rationality.

Mother Nature's pragmatic and efficient principles dictate that these hormones should also help the baby at birth, and this is being increasingly confirmed by scientific research. This hormonal interdependence contradicts the common medical response to natural birth as the mother's prizing of her own experience over her baby's safety, and underlines the mutual dependency of mother and baby, even as they begin their physical separation.

Oxytocin

Oxytocin has been called the hormone of love because of its connection with sexual activity, orgasm, birth, and breastfeeding. In addition, oxytocin is produced in social situations such as sharing a meal, making it a hormone of altruism or, as Michel Odent regularly suggests, of 'forgetting oneself'.

Oxytocin is also the most powerful uterotonic (contraction-causing) hormone, and its release is associated with the contractions of labour and birth in all mammalian species. Oxytocin is made in the hypothalamus, deep in the middle brain, and is released in pulses from the posterior pituitary into the bloodstream every three to five minutes during early labour, becoming more frequent as labour progresses.

The number of oxytocin receptors in a pregnant woman's uterus increases substantially late in pregnancy, increasing her sensitivity to oxytocin. Oxytocin has also

been shown to have a painkilling effect in rats and mice.

Oxytocin catalyses the final powerful uterine contractions that help the mother to birth her baby quickly and easily. At this time, the baby's descending head stimulates stretch receptors in a woman's lower vagina, which trigger oxytocin release from her pituitary. This oxytocin release causes more contractions that promote more fetal descent, inducing more stretch-receptor stimulation and therefore even more release of pituitary oxytocin. This 'positive feedback loop' is also known as the Ferguson reflex.

Skin-to-skin and eye-to-eye contact between mother and baby also help to optimise oxytocin release

After the birth, ongoing high levels of oxytocin, augmented by more pulses released as the baby touches, licks, and nuzzles the mother's breast, help to keep her uterus contracted and so protect her against postpartum haemorrhage. Skin-to-skin and eye-to-eye contact between mother and baby also help to optimise oxytocin release. Blood oxytocin levels peak at around thirty minutes postpartum and subside towards the end of the first hour. Oxytocin levels in the brain, which switch on instinctive maternal behaviour, may be elevated for substantially longer.

Newborn oxytocin levels also peak at around thirty minutes after birth so that during the first hour after birth, both mother and baby are saturated with high levels of oxytocin, the hormone of love. Newborn babies have elevated levels of oxytocin for at least four days after birth, and oxytocin is also present in breastmilk.

During breastfeeding, oxytocin mediates the milk-ejection, or letdown, reflex and is released in pulses as the baby suckles. During the months and years of lactation, oxytocin continues to act to keep the mother relaxed and well nourished, by enhancing the efficiency of her digestion. Other studies indicate that oxytocin is also involved in cognition, tolerance, and adaptation, and researchers have recently found that oxytocin also acts as a cardiovascular hormone, with effects such as slowing the heart rate and reducing blood pressure.

Uvnas-Moberg describes a 'relaxation and growth response' to oxytocin release,[2] which reflects its ability to turn on the parasympathetic nervous system, which is involved with digestion and growth, and to reduce activity in the sympathetic 'fight-or-flight' system. Malfunctions of the oxytocin system have been implicated in conditions such as schizophrenia, autism, cardiovascular disease, and drug dependency, and it has been suggested that oxytocin may mediate the antidepressant effect of drugs such as Prozac.

Beta-endorphin

Beta-endorphin is one of a group of naturally occurring opiates (drugs derived from the opium poppy), with properties similar to pethidine, morphine, and fentanyl, and has been shown to work on the same receptors of the brain. It is secreted from the pituitary gland under conditions of pain and stress, when it acts to restore homeostasis (physiological balance); for example, by acting as a natural painkiller. Beta-endorphin also activates the powerful mesocorticolimbic dopamine reward system, producing reward and pleasure in association with important reproductive activities including mating, birth, and breastfeeding. Beta-endorphin is also released during episodes of social and physical contact, reinforcing pro-social behaviours among all mammals.

Like the addictive opiates, beta-endorphin reduces the effects of stress and induces feelings of pleasure, euphoria, and dependency. Beta-endorphin levels, as measured in the mother's bloodstream, increase throughout labour, peaking at the time of birth, and subsiding in the first one to three hours. Levels in the new mother's limbic system are elevated for much longer, as beta-endorphin takes more than twenty-one hours to break down within the brain and cerebrospinal fluid (CSF).

In labour, such high levels help the labouring woman to transcend pain, as she enters the altered state of consciousness that characterises an undisturbed birth. In the hours after birth, elevated beta-endorphin levels reward and reinforce mother-baby interactions, including physical contact and breastfeeding, as well as contributing to intensely pleasurable, even ecstatic, feelings for both.

Beta-endorphin is also important in breastfeeding. Levels peak in the mother twenty minutes after commencement, and beta-endorphin is also present in breastmilk. Researchers have found higher levels, at four days postpartum, in the breastmilk of mothers who have had a normal birth, compared with caesarean mothers; they speculate that this extra dose of beta-endorphin is designed to help the newborn with the stressful transition to life outside the womb.

Beta-endorphin, as a component of ongoing mother-baby interactions, induces a pleasurable mutual dependency for both partners, reinforcing and rewarding behaviours such as breastfeeding and physical contact that are associated with long-term well-being and survival.

Catecholamines

The fight-or-flight hormones adrenaline and noradrenaline (epinephrine and norepinephrine in US literature) are part of the group of hormones known as catecholamines (CAs) and are produced by the body in response to stresses such as hunger, fear, and cold, as well as excitement. Together they stimulate the sympathetic nervous system for fight or flight.

During labour, maternal CA levels slowly and gradually rise, peaking around transition. However, high adrenaline levels in early labour, which reflect activation of the woman's fight-or-flight system in response to fear or a

perception of danger, have been shown to inhibit uterine contractions, therefore slowing or even stopping labour. Noradrenaline also acts to reduce blood flow to the uterus and placenta and therefore to the baby.

This reflex makes sense for mammals birthing in the wild, where the presence of danger would activate the fight-or-flight response, inhibiting labour and diverting blood to the major muscle groups so the mother can fight or, more likely, flee to safety. In humans, high levels of adrenaline have been associated with longer labour and adverse fetal heart rate (FHR) patterns, which indicate that the baby is low in oxygen (hypoxic), consistent with CA-mediated reductions in uterine blood flow.

Research has also shown that very high CA levels can paradoxically stimulate uterine contractions, which may contribute to the fetus ejection reflex. According to Odent, this reflex occurs at transition, or perhaps even earlier in labour, and almost always follows an undisturbed birth, perhaps because low CA levels in early labour are necessary for its full expression. The mother experiences a sudden and enormous increase in CA levels, giving her a rush of energy and strength; she will be upright and alert, with a dry mouth and shallow breathing and perhaps the urge to grasp something. She may express fear, anger, or excitement, and the CA surge will produce, in concert with high oxytocin levels (associated with the Ferguson reflex), several very strong and irresistible contractions that will birth her baby quickly and easily.

After the birth, the new mother's CA levels drop steeply. If she is not helped to warm up, the cold-related stress will keep her CA levels high, which will inhibit her uterine contractions and therefore increase her risk of postpartum haemorrhage.

For the baby also, labour is an exciting and stressful event, reflected in increasing CA levels. In labour these hormones have a very beneficial effect, protecting the baby from the effects of hypoxia (lack of oxygen) and subsequent acidosis by redistributing cardiac output (blood supply) and by increasing the capacity for anaerobic glycolysis (metabolism of glucose at low oxygen levels).

The baby experiences a marked surge in CA hormones, especially noradrenaline, close to the time of birth, probably triggered by pressure on the head. This surge plays a very important role in the baby's adaptation to extrauterine life. It aids newborn metabolism by increasing levels of glucose and free fatty acids, which protect the newborn's brain from the low blood sugar that can occur in the early newborn period when the baby loses the placental supplies of glucose.

In addition, catecholamines enhance respiratory adaptation to life outside the womb by increasing the absorption of amniotic fluid from the lungs and stimulating surfactant release. Surfactant is essential for smooth inflation of the newborn lungs. CAs also assist with the necessary newborn shift to nonshivering thermogenesis (heat production), increase cardiac contractility, stimulate breathing, and enhance responsiveness and tone in the newborn.

High CA levels at birth also ensure that the baby is wide-eyed and alert at first contact with the mother. The baby's CA levels also drop steeply after an undisturbed birth, being soothed by contact with the mother, but noradrenaline levels remain elevated above normal for the first twelve hours. High newborn noradrenaline levels, triggered by a normal birth, have been shown to enhance olfactory learning during this period, helping the newborn to learn the mother's smell.

Prolactin

Prolactin, known as the mothering or nesting hormone, is released from the pituitary gland during pregnancy and lactation. Prolactin is named for its well-known prolactation effects, preparing a pregnant woman's breasts for lactation and acting postnatally as the major hormone of breastmilk synthesis.

Prolactin levels increase throughout pregnancy, helping to organise the expectant mother's brain for maternity. Prolactin's lactogenic (milk-producing) effect is blocked during pregnancy by high levels of progesterone, produced by the baby's placenta. When progesterone levels drop with the birth of the placenta, prolactin can begin stimulating milk production.

Prolactin levels decline during labour, reaching the lowest point when the labouring woman's cervix is fully dilated. Prolactin then rises again steeply in the moments after birth, perhaps due to stimulation of the mother's cervix during birth, reaching peak levels in the following two to three hours. After this, levels decline again slowly and reach another nadir from nine to twenty-four hours postpartum.

optimising maternal behaviours at this time

This postpartum maternal surge in prolactin provides maximum levels, available to brain and body, in the hour or so after birth. This elevation may be important in optimising maternal behaviours at this time, as well as ensuring successful lactation.

Animal studies show that prolactin release is also increased by carrying infants, and its association with paternal nurturing (including in humans) has earned it the added title 'the hormone of paternity.' Human studies have shown that just before the birth, fathers-to-be have elevated prolactin levels, which parallel the rise of prolactin in their partners. New fathers with higher prolactin levels are more responsive to newborn cries.

In summary

Mother Nature's superb design is hard-wired into our female bodies, providing an elaborate orchestration of hormones to enhance ease, pleasure and safety in labour, birth and postpartum. These hormones also ensure an

ideal start to, and ongoing pleasure and reward from, breastfeeding and attachment, optimising well-being and survival for mother and offspring in the medium and long terms.

The full expression of these labouring hormones requires specific conditions: that the labouring mother feels private, safe and unobserved. This basic need is recognised by traditional systems of maternity care, which prioritise the emotional well-being of the labouring woman and ensure that she is cared for in a familiar place with known and trusted helpers. These factors will keep her as calm and relaxed as possible, and her adrenaline levels low.

adrenaline levels will increase, slowing labour and decreasing blood and oxygen supply to the baby

Conversely, if she is not feeling private, safe and unobserved in labour, her adrenaline levels will increase, slowing labour and decreasing blood and oxygen supply to the baby and leading to fetal distress for vulnerable babies. Our current maternity care system does not recognise this basic need, and the majority of intervention is done for slow labour and fetal distress. Interventions used for these indications such as synthetic oxytocin and caesarean surgery can further interfere with the hormonal orchestration for mother and baby, creating a cascade of intervention and depriving both of the ideal start that Mother Nature intends.

As Professor Kloosterman states so eloquently:
'Spontaneous labour in a normal woman is an event marked by a number of processes so complicated and so perfectly attuned to each other that any interference will only detract from the optimal character. The only thing required from the bystanders is that they show respect for this awe-inspiring process by complying with the first rule of medicine – nil nocere [do no harm].'

Sarah Buckley

Following her recent UK seminars (recorded and available on DVD) Sarah adapted Chapter 6, Undisturbed Birth: Mother Nature's Blueprint for Safety, Ease, and Ecstasy, of her book Gentle Birth, Gentle Mothering, to produce this article for AIMS. Sarah's books, DVDs and articles are available at www.sarahbuckley.com

Reference

1. Buckley, SJ (2009) Gentle Birth, Gentle Mothering. Celestial Arts
2. Uvnas-Moberg, K (2011) The Oxytocin Factor: Tapping the Hormone of Calm, Love and Healing. 2nd edition. Pinter & Martin Ltd.

Further references and additional reading suggestions are available at www.sarahbuckley.com/undisturbed-birth-aims-references

Stop Press

Jo Murphy-Lawless sends news on Ireland's midwifery unit closures

Bleak news from Ireland became still more bleak last week. Following the downgrading and closure of two of our six midwifery-led initiatives to support women in good birthing, we learned that Cavan Midwifery-Led Unit was to be closed without any public discussion.

Cavan is one of only two MLUs in the Republic (the other is in Drogheda, also in the northeast of the country.) Cavan opened in 2005 after tremendous work by the Kinder Maternity Task Force, a pioneering effort to bring midwifery-led care into being.

Both MLUs were the subject of a full-scale randomised controlled trial commissioned by the Health Services Executive (HSE), the Mid U Study, which reported in 2009 with excellent data on the favourable outcomes for women using the MLUs. Even within the restrictive conditions governing these two MLUs, outcomes proved MLU care at least as safe for women as birth in the consultant-led units to which they are attached, with far fewer interventions, and they are, economically, more cost-efficient.

The HSE, now focused on 'savings', saw closure as a 'cost-cutting measure'. Medical opponents to the unit saw it as their good chance. The Caesarean section rate in the consultant unit in Cavan currently stands at 28.3%, above even the national average in Ireland of 27%. There was not a whisper about savings to be made in that arena, but then that is the purview of much lucrative private obstetric practice.

The HSE argument was that the MLU was 'under-utilised'. What was left unsaid was that local GPs and obstetricians have consistently failed to support Cavan MLU or to refer women to the MLU. Its sister MLU in Drogheda, sixty miles away, has a waiting list of women anxious to receive evidence-based woman-centred care.

Feverish behind-the-scenes activity gained a temporary reprieve on 16 December 2011, with some tough targets to meet, but the questions remain: why are women in Cavan not being told what the women in Drogheda clearly know about genuine midwifery care? How can we keep this care from vanishing?

Jo Murphy-Lawless
December 2011

The age of research

Sara Wickham takes a critical look at research knowledge: making space for new and old

In this age of information, no matter whether you are a parent seeking information online, a midwifery or childbirth education student writing an essay, an activist listening to the radio or a health care professional reading the latest journal, you are likely to hear, read or otherwise encounter reference to a recent research study approximately every 17.94 minutes. (Actually, I made that statistic up, but it's probably not that far off the truth.) Emphasis often seems to be placed on the fact that the research is new (and, by implication, way more sparkly and interesting than the study on the same topic that was mentioned last week), but this is an important aspect of research that I think is worth questioning.

For example, many students of midwifery, childbirth education and related areas will, as you are reading this, be beavering away writing their own essays, dissertations and assignments; probably following the guidelines set out for them by their tutors and the institution at which they are studying. As the AIMS Committee has been hearing more and more of late (which I know because they asked me to write this piece as a consequence of their experiences of this trend), these guidelines increasingly insist that the research and other papers that students are discussing and referencing in their essays have been published within the past ten years. I have noticed the same trend when submitting details of continuing education workshops in countries where midwives need to undertake a certain number of 'approved' study days in order to maintain their registration. Some of the proformas which are sent out for such purposes insist that the reference list should be current within the last three or four years, and, while I understand that the aim is probably to ensure that sessions are current and relevant, it often makes me wonder how people who are lecturing on the historical aspects of a topic fare when filling them out. Concurrently, many libraries are dispensing with older stock, which also includes the discontinuation of subscriptions to older issues of online or print journals, and we increasingly encounter the idea that 'newer is better' as we stumble upon, navigate and trawl information throughout the day. I am writing this article as a response to this trend, which has the potential to influence us all, yet which carries a number of negative consequences in relation to the richness, depth and contextualisation of our knowledge.

Before I defend the role of 'older' research though, I do want to emphasise the importance of current thinking. None of what I am about to say should be taken to mean that it is not important to read the latest research, evidence, guidance and discussion, because this is paramount. I do have some concern, though, about the moves described above, because older studies can offer us so much, in a number of areas, and for a variety of reasons. Perhaps the most important reason for reading older research relates to its importance in framing current debates, and I would like to offer a couple of examples to illustrate this.

I am often asked to speak about the use of anti-D immunoglobulin in maternity care and one of the questions I am often asked by participants in these sessions is about the 'window' of 72 hours within which we are told that anti-D should be offered following a sensitising event. Many people are surprised when I tell them the origin of this window. It made its way into the recommendations because the first trials of this product were undertaken on prisoners prior to the introduction of anti-D in the 1970s (which is a whole other ethical debate, but we'll perhaps save that for a different article) and the researchers chose the 72-hour window because it fitted their protocol, probably for practical reasons. It may well be that anti-D is effective after 84 hours; perhaps even after 96 or more, but we don't know that because the research didn't use that timeframe. So I tell midwives: it's worth giving it even if you miss the window by a bit, though probably six weeks later is too late, because the limitation in our knowledge comes from the early research and no-one has gone back to test it since, not least because of ethical concerns. I probably don't need to add the implication: someone who looked at research only from the past ten years would have no idea of the origins of this window and would have nowhere to turn to gain this knowledge. (Well, unless they read this article, but surely we need to spend at least some of our time generating and discussing new ideas rather than reiterating old ones so that the latest generation of readers will see them?)

older ones were important for a number of reasons to do with context

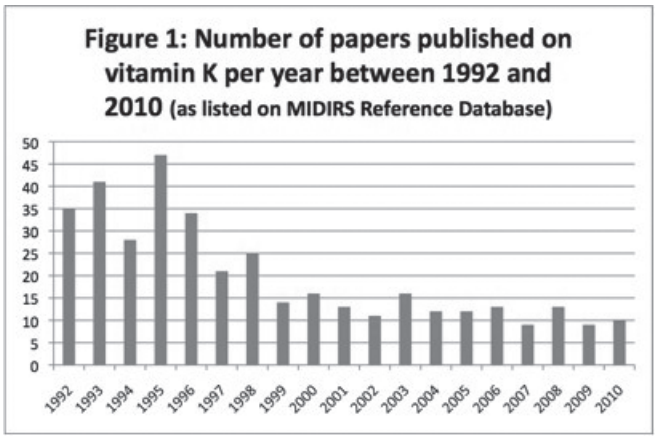
The second example (and I am picking these fairly randomly from literally hundreds of possibilities) relates to what we know about the birth of the placenta. A few months ago, Nadine Edwards and I updated the AIMS booklet on this topic, and we gathered quite a few mounds of studies and papers in order to do this. These included many recent papers – because this is one area where research is very much ongoing; a point to which I shall return below – but also a lot of older ones. The older ones were important for a number of reasons to do with context. It is in the older papers that we could see – and thus critique – the trials and studies on which current policies are still based. (No-one has told the

authors of many guidelines not to use older papers, by the way!) The older papers provide really important and often very interesting information about how perceptions and practices in this area have changed, and, again, they illustrate the way in which one idea that was published in a paper thirty or forty years ago can still impact practice today. Which is pretty important stuff, especially as these ideas may not have been the results of the research per se, but a one-line comment made by the researcher. For a great example of this you only need to look at Michel Odent's sentence about the theoretical risk of water embolism, which sadly influenced policies in many areas and limited thousands of women in their choices around the birth of their placenta.[1]

It is very important to bear in mind that, if one is looking at a study published thirty years ago, the practices that women were experiencing would have been rather different, and their lives would be different from the lives of women today in several important aspects. This is sometimes given as a justification for not using older research, and certainly I would agree that it is vital to look at the context of any research, which includes the setting in which a study was carried out. But, again, many of the practices which women are facing – and sometimes challenging – today are based on this research, and so it continues to be important to look at it and see what it can tell us.

Another important issue is the quality of the study; and this is a key consideration no matter when it was published. Some years ago, Jo Alexander wrote an article called 'Midwives, research ... and the consumption of fine wine'[2] in which she compared research to wine and talked about the roles of the critical consumer, critical provider, producer and quality controller. I was reminded of her article when thinking about this one, because I think there is another sense in which research is like wine. Some studies and papers, like some wines, age really well and are still very palatable – perhaps even juicy – many years after publication, while others are best enjoyed young and perhaps do not have the 'legs' to last. I certainly have some 'old favourites'; papers that would not pass the ten-year rule, yet which I recommend to students because I believe they still have valuable things to say.

In some areas, it can be important to look at older research because, for whatever reason, the topic has not been the focus of recent studies. To use an AIMS example; we have, as above, recently updated the booklet relating to the birth of the placenta but not the one on vitamin K. This is for no other reason than the fact that there has been very little published on vitamin K in the past few years, and what has been published hasn't added anything of significance to our knowledge, so the content of the AIMS booklet on this topic is still up-to-date. By contrast, a fair amount had been published relating to placental birth, and some significant changes had occurred in our understanding of this area, so it was important to update that booklet to reflect this. In fact, I feel quite sorry for the student writing a dissertation on vitamin K who was trying to adhere to the ten-year rule: I just did a quick search on the MIDIRS database and made the graph above (figure 1), which shows the number of papers published on this topic for each year between 1992 and 2010. As the graph shows, the number of published papers has diminished significantly. Again, context is everything, and for the purposes of updating booklets it thus seems sensible to focus efforts on areas in which knowledge is rapidly evolving – a nuance which would easily be missed if one was choosing literature by publication date alone. Furthermore, while vitamin K is also a good example of an area that is desperately in need of a randomised controlled trial but within which such studies have not been carried out, there are other areas where even the most recent trials are more than ten years old and it would seem imperative for someone writing a dissertation to include them.



As I write, I am also reflecting on just how often I have drawn on the idea of context in this article, and that is probably the key issue that concerns me when I consider the bias against older studies. No matter whether you are an activist seeking to effect change, a parent seeking information on which to base decisions, a midwife reflecting on what you do on a daily basis or a student seeking to understand an area in greater depth, it seems to me to be vitally important to be able to learn about the origin of certain knowledge and practices and to use research which may well be older but which is still the most relevant or most recent that we have. The context of knowledge cannot be separated from the knowledge itself, and if we limit ourselves by publication date, we limit our ability to understand where we have come from, to learn from the gems of past work and to stand on the shoulders of those who came before. Let's not force a choice between new sparkly studies and those that are more mature: it seems really clear to me that we need to make space for both.

Sara Wickham

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Time to put up or shut up?

Rosemary Mander talks about the perceived problem of being pregnant and fat

Media attention is currently focusing strongly on the problems of obesity and being overweight; they are widely said to have reached 'epidemic' proportions. It is likely that the media has actually contributed to this perception of an epidemic, although the responsibility of the USA, where obesity is even more prevalent, cannot be ignored. Most of the concern about obesity has related to its incidence among children and young people, largely because of its adverse effects on their health and, possibly, shortening their lives. While obesity among childbearing women does not appear to have merited so many column inches, it is reported to be not only the cause of ill health among childbearing women and newborn babies, but also possibly associated with an increased risk of death.

In thinking about overweight and obesity, it is not possible to separate the current spate of condemnation from thoughts about fashion and the desirability of being 'size zero'. Thus, cultural, social, economic and political factors, as well as illness, are likely to be having an influence on attitudes to body size.

Public awareness of the problems of obesity among childbearing women is quite a recent phenomenon. It was the 'Confidential Enquiries' of 2007,[1] that really highlighted the links between the mother being obese and the risk of poor health outcomes, such as clot formation, infections, heart problems and anaesthetic difficulties. This awareness has only been increased in the more recent report.[2]

Prior to the widespread introduction of the Body Mass Index (BMI), maternity staff were more interested in the woman's weight gain during pregnancy as an indicator of fetal and maternal well-being, than in the woman's long-term size. The BMI, computed by dividing your weight in kilograms by your height in metres squared, is a relatively simple calculation, which may account for its general popularity and frequent use.

While the BMI is a straightforward formula, the messages which the result carries are more complex. These include a wealth of value judgements about the obese person's lifestyle and responsibility (or lack of it) for their body shape. Such judgements feature many real or imaginary personality characteristics, particularly those relating to overeating and to lack of physical exercise, which have been summarised as 'gluttony' and 'sloth' respectively. Judgements like these bring to mind the phenomenon encountered in many situations when the person who is the victim is actually blamed for the problem or illness that has befallen them.

Among both the popular media and professional publications the link between obesity and health problems has all-too-frequently been assumed to be direct. This has taken the form of perceiving obesity to be the reason for the condition; that is, the cause of the effect. Such simplistic assumptions are common among health professionals; one example was the Peel Report,[3] which concluded that the fall in the number of babies dying around the time of birth was directly due to more women giving birth in hospital. This direct cause and effect link manifested itself in a recent CMACE report,[4] when the Foreword mentioned:

'the impact that obesity has on women's reproductive health and that of their babies.' (2010:xiii)

Obviously, for the overweight or obese woman the picture is not that clear-cut. A woman's obesity may be associated with less-than-healthy eating habits, due to multiple family obligations and a hectic lifestyle; which, in turn, means that she may smoke and face other health problems.

What has attracted far too little attention is the woman's experience of being overweight or obese in the maternity care system

The costs of obesity to the health service, the poor maternal health rates and the association between the mother's obesity and the baby's unsatisfactory condition have all been well-publicised. What has attracted far too little attention is the woman's experience of being overweight or obese in the maternity care system. The woman's view is starting to be considered, but there has been minimal interest in what she is able to actually do about the situation in which she finds herself. This lack of interest manifested itself most obviously in the recent CMACE report,[4] which specifically and deliberately excluded consideration of any self-care interventions during pregnancy. The focus of the CMACE report was largely on the need for the woman to be advised and to undertake weight reduction interventions preconceptually, that is, prior to becoming pregnant. While such advice may be very helpful to some groups of women, for others it represents an unrealistically idealised recommendation. For women whose relationships are something other than conventional or who feel that their body clock is ticking relentlessly away, planning weight loss before conceiving may be little more than a counsel of perfection.

That women are all too aware of the problems caused by being overweight or obese during pregnancy and try

to do something about it should come as no surprise to health care providers. This was the finding of a large research project in the USA which Bish and her colleagues published in 2009.[5] Increasing numbers of women reported that they tried to lose weight either by reducing their food intake or by increasing their physical exercise, or both. These researchers indicated that such weight loss strategies were in direct contradiction to the advice given by health care providers. Although the researchers admit that there is a lack of research into the effects of weight loss during pregnancy, they do suggest that it may be associated with the baby being low birth weight due to being born prematurely.

A more recent and more authoritative systematic review by Dodd and her colleagues[6] sought to address specifically the value of any things that the overweight or obese woman could do during pregnancy to reduce any harm to herself and her baby. Again the possibility of change of diet was considered as well as the introduction of an exercise regime. The studies that have been undertaken have not been of a sufficiently high quality to draw any definite conclusions or to be able to offer the childbearing woman meaningful advice about what she is able to do to help herself.

Conclusion

Childbearing women are being bombarded with criticisms about their body size by the popular, professional and other media and by those who should be providing care. These negative messages are conveyed without being able to give help or information about what the woman is able to do to remedy the situation. This sad scenario inevitably leads to the question of, if there are really so many obese women and being overweight carries such serious implications, why has there been so little research on interventions during pregnancy?

This may be one of those situations in which health care providers should admit that they have no remedy to offer the woman who is pregnant. This admission should be made before berating and condemning the childbearing woman on the grounds of the size of her body.

Rosemary Mander

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High risk or unknown quantity?

When I was 19 I found out I was pregnant – I have Perthes disease, which is uncommon in females.

Perthes' disease occurs in a part of the hip joint called the femoral head. This is the rounded top of the femur (thigh bone) which sits inside the acetabulum (the hip socket). Something happens to the small blood vessels which supply the femoral head with blood so parts of the femoral head lose their blood supply. As a result, the bone cells in the affected area die, the bone softens, and the bone can fracture or become distorted. The severity of the condition can vary. [Explanation from the Perthes Association]

I have always lived with pain and discomfort and there had always been some concern if I were to fall pregnant. At the time (the pregnancy was unplanned) I was taking pain medications and there was a lot of concern about the damage I may have done. I saw the midwife who brusquely told me that my pelvis would not hold the baby for more than seven months and then they'd section me.

referred to as awkward and stupid

I was horrified. It was the last thing I wanted. I argued my case; for a start I was single, how would I manage to be bed bound? I didn't want one! I had plenty of discussions about being selfish and putting my baby at risk and was often told I'd be held accountable if my baby died. I was so frightened no one would support me and I was referred to as awkward and stupid. In a routine physio appointment I burst into tears. The physio sat with me, she was the only person who heard what I was saying. We put together a plan of positions to keep my pelvis nice and open. The pregnancy was a little uncomfortable toward the end.

I came up with a birth plan that kept my options open. I'd go into labour and wait and see how baby was doing. I'd be 'allowed' to labour for 12 hours then I'd be taken for a section. If baby didn't arrive by 40 weeks I'd be booked for a caesarean.

I agreed to all this – it felt like I was being done a favour! Luckily my daughter made her entrance three weeks before the EDD – on the sofa. I didn't have time to do much apart from call for an ambulance, they were marvellous.

She emerged with no problem at all – I was on my back, almost sitting, and she just slid out in three pushes.

I have had two other babies after her with no problem. I wonder how much my care team even knew about the issues they were suggesting surgery to 'fix'.

Sarah Holdway

‘Obesing’ pregnant women

Ruth Deery asks by whom and for what reasons?

Anti-obesity campaigns and policies remain rife in the media, occupying a high profile in health policy and public health agendas, often interpreting obesity as a disease of global epidemic proportions and a ‘health time bomb’.

Not surprisingly, obesity is similarly conceptualised, both scientifically and medically, by those working in and writing about the maternity services. The moral agenda attached to the anti-obesity culture has many similarities to the presentation of the AIDS epidemic in the 1980s, where stigmatisation and marginalisation from mainstream citizenship were clearly evident.

arbitrarily label obesity as a cause rather than a correlation

Pregnant women receive clear messages that if they are obese they have a greater risk of developing a range of complications in pregnancy and childbirth.[1] As a result obesity becomes increasingly and unevenly medicalised through so-called ‘authoritative’ accounts[1, 2] that arbitrarily label obesity as a cause rather than a correlation – smoking causes lung cancer comes to mind. These ‘authoritative’ accounts often contain unsubstantiated or overstated claims about the damaging effects of body fat on the health of pregnant women and their babies and can transmit a culture that health professionals know best about risk.[3]

In this respect the ‘black box, junk in; junk out’ scenario comes into play – inconclusive, incorrect evidence is deposited into the box, and reappears at the other side of the black box as legitimate conclusions.[4] As a result the media and health professionals (to mention but a few) leap to groundless conclusions that any possible health problems (such as hypertension, diabetes, heart disease and cancers) are caused by obesity. Other legitimate forms of evidence simply do not enter into the public domain for discussion and debate; the regurgitated ‘junk’ is merely asserted without reference to work that demonstrates otherwise, or questions the credibility of the findings. This situation has created a powerful and pervasive discourse where the health risks associated with obesity are often communicated as scientifically based fact and obesity is viewed as a dangerous disease.

As well as having health issues blamed on their body size, obese pregnant women are also more likely, than their counterparts, to receive judgemental comments from medical staff.[5, 6] Clearly when a more accepting approach to medicalisation by health professionals does not happen, social discrimination, stereotyping and stigmatisation occur much more frequently. When these negative social responses come into play the effect on pregnant women is easily ignored or forgotten and women are judged on the basis of their size and appearance.[6]

When pregnant women receive judgemental or negative feedback from health professionals these comments can become internalised, causing women to become withdrawn and feel isolated. Crucially, words are not always necessary and our own internalised views and opinions about ‘obesity’ can easily be transmitted subliminally to women and their families, thereby increasing the potential for marginalisation even further.

Additionally, some health professionals view obese women as ‘a statistic waiting to happen’[5] but not all obese women will present as problematic; the degree of risk will vary, for example there will be a difference between a well nourished and an under nourished pregnant woman. Research suggests there is a lack of knowledge amongst health professionals of the social, psychological and economic effects that influence obesity and personal well-being.[7] Again, this adversely influences access to maternity services, quality of care, health equity, and outcomes of care, for women who are more vulnerable and disadvantaged.[7]

obesity is neither genetic nor physiological

A consensus has emerged that obesity is neither genetic nor physiological.[8] Rather, being obese is associated with a broad range of social, psychological and economic effects on a pregnant woman’s life.[6, 7] At the same time, the failure of dietary approaches has led to a greater consideration of a wide range of possible risk factors that appear to be correlated with obesity. These include psychological factors, eating patterns, activity levels, family background and amount of sleep. Eating in response to emotional rather than hunger cues could also be more prevalent among overweight and obese individuals. This is an area that warrants much more urgent attention from health professionals and researchers. Associated with discrimination and stigmatisation, obese people may externalise a sense of guilt that will impact on their social interactions, possibly leading to more negative

experiences with health care. There is no reason to believe that this situation will be any different for pregnant obese women. Likewise, as obesity has become progressively medicalised, midwives have become either blind to, or more accepting of, social discrimination, stereotyping and stigmatisation that can occur as they work with pregnant 'obese' women.[5, 6, 7]

being overweight has been associated with many different negative psychosocial consequences

Those pregnant women who come from communities with low levels of social capital may be particularly at risk – both of being obese and of suffering from the associated effect of low self-esteem.[8] Lower socio-economic status also seems to be a risk factor for increased levels of obesity, particularly in women and members of ethnic minorities.[8] Environment may also be related to the accessibility of healthy food although proximity to appropriate shops does not necessarily make healthy food accessible to everyone.[9] Financial resources, mobility, and expertise in cooking are also factors to take into account.

Environmental factors may also contribute towards weight gain. People in areas characterised by lower social support, and therefore higher levels of stress, may be at higher risk of becoming obese. In addition, being overweight has been associated with many different negative psychosocial consequences that may in turn further contribute to higher levels of stress.[5, 6, 7] If obese pregnant women feel that they are entering into a maternity culture that deplores and labels obesity as anti-social, stress levels will increase even further, encouraging marginalisation and increasing vulnerability.

All those people coming into contact with pregnant women would do well to heed the advice of Lucy Aphramor, a dietician who founded the group Health at Every Size (HAES). She advocates the removal of weight loss goals promoting a healthy relationship with food, including the importance of learning to recognise internal signals rather than ignoring them in favour of rigid eating plans. HAES encourages activity for general well-being, for pleasure in movement and abilities and not as a calorie-burning mission.[10] What better advice could midwives give to pregnant obese women? Aphramor also advocates that bodies should not be disliked or despised for their lack of conformity to a particular size or shape. Whilst the HAES approach may or may not result in a weight change, the point is that HAES improves health outcomes long-term, and dieting does not, making HAES an ethical and effective choice. However, and crucially, how confident do those people (especially midwives) coming into contact with obese pregnant women feel giving advice regarding dietary issues? My guess is that much work needs to be done in this area in order to build confidence in the health professionals and to instil a sense of safety and trust for obese pregnant women.

Conclusion

Further research needs to explore to what extent poor health outcomes for mother and baby are actually linked to obesity. The role of health professionals in the planning of care for pregnant obese women may in some way subliminally effect poor maternal outcomes. Acceptance and further understanding of diverse body sizes is crucial if we are to ensure equal access to excellent standards of care in the maternity services. Eating less and moving more is not an all-encompassing answer to the so-called 'obesity epidemic' – all bodies are worthy of respect whatever their size or shape and account must be taken of the different ways in which some people 'use' food. Health professionals must be sensitive to the current obesity rhetoric, recognising how misconceptions can easily influence the way we care for pregnant women. This will only be achieved if those coming into contact with obese pregnant women are given the opportunity to become skilled in their approach to advice giving.

Ruth Deery

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Government Position

The Department of Health has published *Healthy Lives, Healthy People: A call to action on obesity in England*. The document can be found here: www.dh.gov.uk/health/2011/10/call-to-action

The Scientific Advisory Committee on Nutrition (SACN) *Dietary Recommendations for Energy* report can be found here: www.sacn.gov.uk/reports_position_statements/index.html

Researching obesity

Sara Wickham offers an overview of four recent studies

As the editor of Essentially MIDIRS, a monthly journal for midwives, it is my happy task to read everything that goes onto the MIDIRS database (www.midirs.org) each week and to decide which articles, papers and studies I want to include in the Update pages of the journal.

I have begun by mentioning this because this task inspired a conversation with Nadine Edwards which in turn inspired me to write this article. I mentioned to Nadine that, over the course of a fairly short space of time, I had read four papers relating to obesity, all of which we had featured in our journal, but which I also felt were really relevant to the readers of AIMS Journal. (Note to self: remember, in future, that AIMS Committee members have been well-trained in conscripting volunteers and rarely respond to such comments by saying: 'Good idea, Sara; I'll write that myself'!) I feel it is important to point out that I haven't done a systematic search of the literature; these are articles which I came upon relatively serendipitously, but all of them have something important to say about the current situation in maternity care as far as the treatment of larger women is concerned.

The first study looked at the experiences of childbearing women who are obese and pregnant in the UK[1] (figure 1) These researchers interviewed 19 women and you will probably not be surprised to see from the abstract that the women's experiences were largely negative, with feelings of humiliation, stigma and distress appearing frequently through their words:

'When you're listening to the heart beat and she's [the midwife] saying, "Which way's she lying? I think this way, but I have to dig a bit deeper with you." She just makes me feel awful for being big. It makes you think that you don't want to be pregnant and that you don't want to go if it's going to save you being told that you're fat. I already know I'm fat. That I don't need to be told'[1]

Furber and McGowan 2011: 439

One area that emerged was the impact that what was written in women's notes could have. This is discussed in the abstract but also illustrated by several of the quotes from the women:

'Mums and aunties love reading through your notes don't they? I remember being embarrassed all the time cos it was literally written everywhere. They take the measurements to work out roughly how big the baby is, don't they? But on every one it was saying increased body mass index, overweight blah blah blah'

Furber and McGowan 2011: 441

It would be nice to think that such studies will quickly impact upon the practice of professionals, but I imagine that most AIMS Journal readers will forgive me for being less than optimistic about the possibility that this situation will change quickly.

Figure 1: Furber and McGowan (2011)

***Objective**: to explore the experiences related to obesity in women with a body mass index (BMI) >35kg/m^2 during the childbearing process.*

***Design**: a qualitative design was used. Data were collected using semi-structured interviews and field notes. Women were interviewed in the third trimester of pregnancy and between three and nine weeks after the birth. Transcribed data were analysed using framework analysis methods.*

***Setting**: one maternity service in the North of England.*

***Participants**: 19 women with BMI >35kg/m^2*

***Findings**: these women highlighted their feelings of humiliation, and the stigma associated with being pregnant, when obese. Interactions with health professionals and the general public reinforced their discomfort about their size. The high risk status of their pregnancy increased the medicalisation of their pregnancy. The ultrasound scan was a significant source of distress if difficulties imaging the fetus were not clearly explained during the procedure.*

***Key Conclusions**: pregnant women who are obese are sensitive of their size. The interactions with health professionals and others that they encounter may increase distress.*

***Implications For Practice**: health professionals should be more aware of the psychological implications of being obese. Communication strategies about care should be clear and honest, and conveyed in a sensitive manner. Written comments related to size on 'hand-held' notes should be explained at the time of writing.*

The next of the studies[2] (figure 2) which was published in the same issue of Midwifery as Furber and McGowan's research,[1] throws some light on one reason why the situation may be as it is. This research looked at the experiences and concerns of health professionals who were caring for women who were obese. The study was carried out in Australia, but I imagine the experiences of caregivers in other Western countries may not be that dissimilar. This study showed that participants (the vast majority of whom were midwives) experienced a number of tensions, and it highlights the way in which, while individual practitioners have to take responsibility for the way they speak to and treat women, a big part of the problem is the speed at which our society's focus on the 'obesity epidemic' has impacted upon systems of maternity care. This has left some midwives and other caregivers not knowing where to turn, as one midwife explains:

'The thing is that it's all become a problem in such a short amount of time, there's not been any provision to put any

services in place. The most we've got is you see now signs around saying we've got big furniture, that's it. We've got big wheelchairs now. We've got big beds and we've got big this and that and the other. That's it, but it's not that there's actually any service, like having to see a dietician.'

Schmied et al 2011: 428

Whether having to see a dietician would be either a positive or effective service for individual women is a matter for debate, but the overall point is clear: midwives had no more warning that obesity was suddenly going to be perceived as the latest significant problem than anyone else, and they have struggled to adapt. The few educational sessions I am aware of that have been offered to professionals relating to this area have focused more on why obesity is a problem than anything else. The main emphasis in many locales has been on the creation of policies which ultimately restrict the choices of women who are labelled as obese and, perhaps as a result, midwives in this study 'identified a lack of skills and knowledge in communicating with obese women about their weight.'[2] One of the participants in Furber and McGowan's study also noticed how all the emphasis seemed to have been placed on furniture for larger women (which, she noted, she didn't feel the need to use). I am sure I am being overly simplistic here, but if each Trust would just use a fraction of the cost of one new bit of furniture to fund discussion sessions where midwives – who also come in all shapes and sizes – could sit alongside women and openly discuss issues of communication, language and dis/empowerment in this area, this would surely go a long way to helping everyone who is struggling with this issue?

Figure 2: Schmied et al (2011)

***Objective**: to explore the experiences and concerns of health professionals who care for childbearing women who are obese.*

***Background**: obesity is increasing nationally and internationally and has been described as an epidemic. A number of studies have highlighted the risks associated with obesity during childbirth, yet few studies have investigated the experiences and concerns of midwives and other health professionals in providing care to these women.*

***Design**: a descriptive qualitative study using focus groups and face-to-face interviews to collect data. Interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis.*

***Setting**: three maternity units in New South Wales, Australia.*

***Participants**: participants included 34 midwives and three other health professionals.*

***Findings**: three major themes emerged from the data analysis: 'a creeping normality', 'feeling in the dark' and 'the runaway train'. The findings highlight a number of tensions or contradictions experienced by health professionals when caring for childbearing women who are obese. These include, on the one hand, an increasing acceptance of obesity ('a creeping normality'), and on the other, the continuing stigma associated with obesity; the challenges of how to communicate effectively with pregnant women about their weight and the lack of resources, equipment and facilities ('feeling in the dark') to adequately care for obese childbearing women. Participants expressed concerns about how quickly the obesity epidemic appears to have impacted on maternity services ('the runaway train') and how services to meet the needs of these women are limited or generally not available.*

***Conclusion And Implications For Practice**: it was clear in this study that participants felt that they were 'not waving but drowning'. There was concern over the fact that the issue of obesity had moved faster than the health response to it. There were also concerns about how to communicate with obese women without altering the relationship. Continuity of care, training and skills development for health professionals, and expansion of limited services and facilities for these women are urgently needed.*

Of course, that idea assumes that it IS an issue that we should have near the top of our agenda, and I really don't want to make that assumption. For every issue that affects women (and perhaps midwives) on such a scale, there are usually social scientists willing to look more deeply at the social, ethical and philosophical elements of the debate, and the third abstract[3] (figure 3) describes one such paper. McNaughton shows how there are some core assumptions at the heart of what she (rather generously in my opinion) terms 'obesity science' and that these assumptions are, not to put too fine a point on it, being used as a further means of monitoring, regulating and punishing women. I can attest (again from my very close relationship with the MIDIRS database) that there has been a massive increase in the number of papers which attempt to link obesity in pregnancy with obesity in babies and children and it is all too easy, especially while we are being constantly bombarded with messages about the extent of the problem, to forget that there remain some very important questions about whether there really IS a problem.

On this note, I have become deeply concerned about some of the papers that report the birth outcomes of women who are labelled as obese, not least because I see how these women are treated differently in practice, as is also evidenced by the papers already mentioned. So I was genuinely delighted to see this being addressed in the literature by the publication of the fourth paper[4] (figure 4). These researchers focused on labour (so there is still plenty of work to be done on the ways in which being constantly told that your shape is a problem during antenatal visits may impact women's sense of self and thus, for example, their ability to relax and labour well in the presence of a midwife who has previously insulted them or made them feel uncomfortable about their shape) and their results are fascinating. Women who had a higher BMI were more likely to be given an oxytocin drip and more likely to have an epidural – which we know is not always the woman's expressed choice but often something that is

Figure 3: McNaughton (2011)

In recent decades overnutrition and obesity have been presented as a looming threat to the health and well-being of children and infants, most notably in western industrialised societies. However, this threat is not simply limited to 'children' who are 'over fed' by their 'parents'. Increasingly, maternal overweight and obesity are said to inhibit conception, cause recurrent miscarriage, pose a serious threat to the development and health of the foetus and have long-term implications for the future well-being of the child. Parental responsibility looms large in these discourses, in which women in particular are held responsible for the future (fat free) health of their offspring from the womb to the tomb. In this article, it is argued that core assumptions at the heart of obesity science have been taken up uncritically in medical arenas focused on conception, pregnancy and reproduction and that this is providing new opportunities for the surveillance, regulation and disciplining of 'threatening' (fat) female bodies. It is shown that although all women of a reproductive age are being brought under the gaze of this deeply punitive medico-moral discourse, it is the bodies, lives and bedrooms of marginalised women that are singled out as posing the greatest 'risk' to their offspring and then targeted for even greater degrees of health/state intervention and surveillance.

recommended to larger women in labour 'in order to reduce the risk of needing a general anaesthetic later should a caesarean section become necessary'. (Talk about being set up to fail!) Larger women were more likely to have an earlier caesarean section (and there is a notable and related decrease in instrumental deliveries) and the overall caesarean section rate is higher for these women – not just because they are 'at higher risk' (whatever that means) but because they are 'managed' differently by professionals, who, let's not forget, have been sold the message that being overweight is problematic and are thus probably more fearful when looking after larger women as a result. So all of the studies which show that being larger is more likely to lead to a caesarean section may be correct, but what Abenhaim and Benjamin's study[4] adds is the evidence that this may not just be because there are risks associated with being larger per se. Instead, professional and service perceptions that being obese is risky are causing individual practitioners to practise differently when looking after larger women. This is probably one of the reasons that women such as those who were interviewed by researchers like Furber and McGowan,[1] the authors of the first study I discussed, feel that their care is overly medicalised.

What a truly, horribly tangled web, and unfortunately I haven't spotted any papers which offer positive suggestions about ways in which we can begin to untangle it. What comes through for me – and I do hope that this doesn't sound defensive, because I absolutely acknowledge that there is plenty that individual practitioners can do to improve things for women – is that it is not simply about needing to educate or upskill professionals. It goes far deeper than that. At the root of all of this is the way in which obesity is perceived in our society, and, while I'm not suggesting that it is by any means an easy task, this is the issue that needs addressing. While the literature on this topic continues to spill out of every corner of the earth, it is no good to any of us if it continues to fail to address the core assumptions that are underpinning the work that is being carried out.

Sara Wickham

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Figure 4: Abenhaim and Benjamin (2011)

***Background**: Higher body mass index has been associated with an increased risk of Caesarean section. The effect of differences in labour management on this association has not yet been evaluated.*

***Methods**: We conducted a cohort study using data from the McGill Obstetrics and Neonatal Database for deliveries taking place during a 10-year period. Women's BMI at delivery was categorised as normal (20 to 24.9), overweight (25 to 29.9), obese (30 to 39.9), or morbidly obese (≥ 40). We evaluated the effect of the management of labour on the need for Caesarean section using unconditional logistic regression models.*

***Results**: Data were available for 11 922 women, of whom 2289 women had normal weight, 5663 were overweight, 3730 were obese, and 240 were morbidly obese. After adjustment for known confounding variables, increased BMI category was associated with an overall increase in the use of oxytocin and in the use of epidural analgesia, and with a decrease in use of forceps and vacuum extraction among second stage deliveries. Higher BMI was also found to be associated with earlier decisions to perform a Caesarean section in the second stage of labour. When adjusted for these differences in the management of labour, the increasing rate of Caesarean section observed with increasing BMI category was markedly attenuated ($P < 0.001$).*

***Conclusion**: Women with an increased BMI are managed differently in labour than women of normal weight. This difference in management in part explains the increased rate of Caesarean section observed with higher BMI.*

Troubled waters?

Sarah Davies looks at the significance of meconium in the amniotic fluid

Amniotic fluid is the fluid surrounding the baby inside the amniotic sac. It plays a vital part in the baby's development, creating a warm protective environment in the uterus where it can grow and move freely. The fluid is secreted from the membranes and the placenta; throughout pregnancy it is continually being 'inhaled' and 'exhaled' by the baby's developing lungs as well as swallowed in and urinated out.

Healthy amniotic fluid smells 'like fresh, clear, warm sea water: heavy, salty and clean.'[1] It is normally clear, but sometimes has a yellowish, greenish or brown tinge when it is stained with meconium. Meconium stained amniotic fluid (MSAF) occurs when the baby opens his/her bowels before birth, and is found in about 13% of labours overall. Approximately 30% of babies born at 40 weeks, and nearly half of babies born after 42 weeks of gestation will have MSAF.[2]

Changing opinions

In the past it was generally believed that MSAF alone was a sign of problems with the unborn baby. For example, a 1988 midwifery textbook has one sentence on the subject, stating *'a greenish colour is indicative of meconium stained liquor and is usually a sign of fetal distress.'*[3] Since then, however, there have been many research studies and the consensus now is that meconium passage alone is not a sign of distress in the baby.[4] For example, a retrospective case control study from Germany (11,226 women, including 1123 who had MSAF in labour) found that the mean arterial pH (measure of oxygenation of the fetal blood) was the same for both groups.[5] In this study, obstetric management was significantly affected by the presence of MSAF; although outcomes for the babies were similar, the caesarean section rate for labours with MSAF was 17.4% compared with 9.6% of the non-affected labours and the vaginal operative delivery rate 13.9% versus 6.2%.[5] This suggests that the management of labour was affected by the clinicians' perception that MSAF was an indication of fetal distress, and therefore they were quicker to intervene. Naoli Vinaver, a Mexican home birth midwife, writes: *'Unfortunately, most conventional medical care providers in most countries around the world misdiagnose the mere presence of meconium as "fetal distress".*
'As a result, they usually perform caesarean delivery within the next few hours. The unfortunate part of this is that the vast majority of these deliveries will result in a worse outcome for both mother and baby than if a vaginal delivery of the baby had been allowed under attentive supervision and care.'[6]

Reasons for MSAF

- MSAF is associated with term/post-term pregnancy and is thought to occur because the digestive system has reached maturity. MSAF rarely occurs before 34 weeks.
- Compression of the head or cord during labour may cause a reflex gastro-intestinal peristalsis (movement of the gut) in the baby. This is a normal physiological response and can occur in the absence of fetal hypoxia.
- Fetal hypoxia (reduced oxygen supply to the baby). The exact cause is unclear, but it is thought that in a hypoxic or compromised fetus, blood is shunted to the brain and heart and diverted from the gut, resulting in gut ischaemia (insufficient blood supply) and increased gastro-intestinal peristalsis.

Degree of meconium staining

MSAF is first noticed when the membranes rupture (this is why some practitioners 'break the waters' to see the colour of the amniotic fluid). The colour can vary from a very light green or yellow tinge (light meconium staining) to a thick, dark green or brown 'pea soup' consistency. Thick meconium is sometimes associated with a reduction in the amount of amniotic fluid. Reduced amniotic fluid both reflects a degree of placental insufficiency, and also predisposes to fetal hypoxia, because of the likelihood of cord compression during labour contractions.[7] However, as Gail Hart, a midwife from the US, writes: *'Meconium itself is not the problem unless it is a sign of severe distress. Even then the problem is the distress rather than the meconium. With good fetal heart tones and a normal labour, even thick meconium is rarely a problem.'*[8] It can be concluded that light MSAF in the term labour is a variant of normal; but thick meconium, accompanied by an abnormal heart rate, would suggest hypoxia.

a healthy baby does not inhale amniotic fluid during labour

Meconium aspiration syndrome (MAS)

MAS is an extremely rare complication, affecting about two in 1000 births, but it is because of MAS that clinicians have concerns about the presence of meconium in the amniotic fluid. MAS occurs when an already hypoxic baby gasps before birth, and inhales meconium into its lungs; a healthy baby does not inhale amniotic fluid during labour. Most cases occur when there has been thick meconium in the amniotic fluid. Meconium is highly irritant to lung tissue and predisposes to infection. The effect of MAS on the baby can vary from a mild form of MAS which resolves in two to three days, to a severe life-threatening pneumonia. This most severe form of MAS has been linked with significant hypoxia prior to birth, although even with thick meconium, the cause and

effect relationship is far from clear. One research study suggested that most cases of severe MAS were not causally related to the aspiration of meconium but rather to other pathological processes occurring in utero, such as chronic asphyxia or infection.[7]

NICE guidelines and care in labour

NICE guidelines state: *'Continuous electronic fetal monitoring (EFM) should be advised for women with significant meconium-stained liquor, which is defined as either dark green or black amniotic fluid that is thick or tenacious, or any meconium-stained amniotic fluid containing lumps of meconium.'*[9] NICE guidelines also recommend that EFM be accompanied by fetal blood sampling; therefore if thick meconium is found in early labour at home, the midwife's advice would be to transfer to an obstetric unit. In the case of light staining, the NICE guidelines state that continuous EFM should be *'considered', 'depending on a risk assessment which should include as a minimum the stage of labour, volume of liquor, parity, the FHR and, where applicable, transfer pathway.'* The NICE guidelines, therefore, advocate a holistic assessment where there is light MSAF. For example, the baby's heart rate can be monitored using a Pinard's stethoscope or a sonicaid, thus enabling the woman to remain mobile, which is beneficial both for optimum oxygenation of the baby and the progress of labour.

meconium stained amniotic fluid in the term or post-term labour is a variant of normal

If there is an irregularity in the baby's heart rate which indicates hypoxia, advice can be sought from *'such qualified health professional as may reasonably be expected to have the necessary skills and experience'*; in this case, it would be an experienced obstetrician (Rule 6, Midwives' Rules, p18). NICE guidelines also recommend that *'healthcare professionals trained in advanced neonatal life support should be readily available for the birth.'* Therefore, if significant MSAF occurs at a home birth the midwife will usually advise transfer to hospital and would definitely do so if this were accompanied by any abnormality of the baby's heart rate.

If thick meconium is identified in the second stage of labour at home, and the birth is imminent, it may be safer to remain at home to avoid the risks of birth during transfer. It is physiologically normal for the membranes to rupture at the onset of the second stage, so this situation occurs fairly often at home births, and rarely results in any problems. Judith Kurutac, an experienced UK independent midwife, observes: *'In 18 years of attending home births, I have not seen a case of meconium aspiration syndrome following a planned home birth. If there is a decision to transfer in from any home birth, the key thing is to ensure that there are the experienced personnel available at the receiving facility to review the clinical presentation and be able to deal with any problems immediately. The midwife needs to give a clear and detailed clinical picture when organising the woman's transfer from home.'* It is important for everyone involved to understand the decision-making timescale and the practicalities of transfer, to safeguard mother and baby.[10]

Care at birth and afterwards

Suctioning of the healthy baby's airways at birth is no longer recommended; this is advised only if the baby has thick or tenacious meconium present in the mouth and/or nose. For home birth the midwife carries equipment for the rare occasion when the baby needs resuscitation. Leaving the umbilical cord intact until it has ceased pulsating will help the baby gradually adapt to extra-uterine life and ensure it has optimum blood volume for full lung expansion. The baby should be kept warm by close skin-to-skin contact with the mother; early nuzzling and suckling will help the baby absorb any mucus and liquid left in its lungs. NICE guidelines advise that where there has been significant meconium staining, the baby should be closely observed at one and two hours of age and then two-hourly until 12 hours of age. Following a home birth the midwife will normally stay for at least the first two hours or until she is satisfied that all is well with mother and baby. On leaving, she should ensure the parents know how to recognise any problems, and who to contact if they have any concerns. Well-informed parents are invariably the most diligent observers of the well-being of their own baby.

In conclusion, meconium stained amniotic fluid in the term or post-term labour is a variant of normal in the vast majority of cases. Parents need to be aware of the current state of knowledge of MSAF in order to make their own decisions about their care, drawing on the expertise of their clinicians as necessary.

Sarah Davies

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The birth of Hannah Jane

Amy Mokady shares her planned home breech birth

On May 1st 2008 I had a perfect home birth. Contractions started after my 19 month old daughter was asleep, and my new baby was born before she awoke in the morning. 'Baby' she said on seeing her new sister, and 'Hat'. I had needed no pain relief other than 45 minutes in the birthing pool, had no tears and no stitches.

A perfect home birth, except that my baby was a complete breech.

It would have been very different, had we followed standard medical practice. She would have been born 10 days earlier by elective caesarean section. My 19 month old would have seen Mummy disappear for at least three days and two nights (assuming no complications), and then for a month or more Mummy would have refused to lift her up and carry her, and all our normal activities would have stopped. (We live in a small village and need to travel everywhere by car.) Her transition to big-sisterhood would have been so much more difficult.

Our journey started at the beginning of my second pregnancy. I had a straightforward and relatively quick hospital birth for my first daughter needing only gas and air, so I was thinking we might try for a home birth second time around. I was still breastfeeding my 10 month old daughter, but my community midwife had never seen anyone pregnant and breastfeeding before. She had to go and check that I would be 'allowed' to continue breastfeeding. This gave me no confidence in her knowledge or ability to support me, so we went straight to Amy and Siobhan, our local Independent Midwives, who were everything we hoped midwives would be!

In Siobhan's words, I 'cruised through' the pregnancy. At 30 weeks we volunteered for an ultrasound training course. 'There's the baby,' said the trainee. 'It's breech.' The consultant told us not to worry because 'lots of babies are breech at this stage and they all turn.' Two of my close friends had had elective caesareans for breech, so I knew that babies didn't always turn. 'Oh, that's a caesarean for us then,' my partner Ed thought with disappointment.

I called Siobhan as soon as we left the building, and asked her to see if there were any alternative options. I didn't understand why it seemed to be fine to deliver undiagnosed breeches vaginally, but not planned ones. I wasn't sure what I would do if my baby didn't turn, but if we ended up with a caesarean I wanted it to be MY choice and MY decision, or truly medically necessary. Ed and I did a lot of reading, and began to question the standard practice of an elective caesarean at 39 weeks. Our overwhelming concern was safety for the baby and for me; to make the best decision for our family as a whole.

We started alternative turning methods (moxibustion, osteopathy and lots of knee/chest position) from 33½ weeks. I had never thought caesareans were too much of a bother, until I was suddenly looking at one for myself. My overwhelming emotion was one of horror on a deep and visceral level – I was healthy and my baby was healthy, I knew my body laboured well, and I found it hard to believe that the only safe way for her to be born was by being cut out.

By 34 weeks, Siobhan had found us a second option. Jane Evans lived nearby and would come to meet us if we were still breech at 37 weeks. Jane is a highly experienced independent midwife who has attended around 100 breech births at home and hospital, and supported many others. She is also author of the AIMS Breech Birth book. We had a true choice – it was all we wanted.

We continued reading and encouraging baby to turn.

At 37 weeks we entered the NHS system. A scan showed baby as breech, spine on the left, with one straight leg and one bent leg. Due to the position of the cord, they could not measure enough fluid to approve me for an ECV (external cephalic version). They booked me in for a repeat scan at 38 weeks and a caesarean at 39 weeks. I mentioned we were considering a home birth – the hospital midwife looked horrified and walked out of the room without saying anything.

The next day we met Jane. She showed us how a natural breech birth works, with the woman on hands and knees. She said she had an overall caesarean rate for breech of 20-25%. She had a presence that reassured us that birth is normal and that breech is just a variation of normal. Most importantly, we saw that Siobhan visibly relaxed about the birth and gained her own confidence that she already knew how to deliver a breech baby from her years of experience and training.

We were convinced. A caesarean rate of 20-25% sounded a lot better than a guaranteed caesarean. We trusted Amy and Siobhan to tell us if we did need to transfer to hospital, a trust built up over the previous eight months of one-to-one care. Our only niggle was that I would really feel safer if we could have the baby in the hospital 'just in case', but it seemed there was no way to do this. The official hospital breech policy specified lithotomy position with forceps on hand, and many of the doctors were not supportive of or confident about breech birth.

At 38 weeks a rescan showed ample fluid. The baby was now breech, spine on the right with both legs bent – a perfect position for a vaginal breech birth. At least our turning efforts had helped her position somewhat! (I had felt her leg bend and it was the most painful moment of either of my pregnancies and births!) The next available

ECV appointment was after my due date, and the next available consultant's appointment was after my caesarean date. The registrar on duty spoke to us and was concerned about our plans to birth at home (the words 'dead baby' were indeed spoken). He was actually very supportive of us wanting a vaginal birth, and surprised that we could not bring our own midwife into the hospital when she had the relevant expertise. We cancelled the caesarean.

At 39 weeks we went in for our consultant's appointment. We wanted to hear as much from the hospital as we had from Jane Evans, to be sure we were making a truly informed decision. We saw a registrar again, who talked us in detail through the risks of a caesarean (I still vividly remember the moment she said, 'there is a risk of cutting the baby') and also why the hospital believed a vaginal breech birth was high risk. (This was mostly to do with the head getting stuck, which all our research had convinced us was highly unlikely in a hands-off birth with experienced practitioners.) This helped to reinforce our decision to continue to plan for a home birth. It also helped that we knew we could change our minds and go in for a caesarean at any time. Importantly for me, Ed fully supported the decision – had he preferred a caesarean then that is what we would have done. We would both have to live with the consequences of this choice.

We felt completely out on a limb. I had found more stories of vaginal twin births than of vaginal breech births. I was infamous at our local hospital. My ideal would have been to labour in the hospital attended by Jane, Siobhan and Amy, but there was no way that this could happen.

We reached 40 weeks. Despite over six weeks spent encouraging baby to turn, she was still stubbornly breech. We knew we had done all we could to get her head-down, and had come to terms with her entering the world bottom first.

Sunday night I had mild contractions all night. They stopped when my daughter woke up.

Tuesday afternoon I had some sudden strong contractions. I went to make some tea. We had no running water! The contractions stopped, leaving me feeling odd and sick. The next few hours were a rush to try to find somewhere else to have the baby. We reached the conclusion that there really was nowhere else to try for an intervention-free breech birth. We preferred the risks of being at home with a midwife who had delivered many breeches to the risks of being in hospital with a stranger who may never have delivered any. The water came back on but my contractions stayed away.

Wednesday afternoon at 4pm my waters broke. Nothing else happened. I had been briefed to expect a quick labour (second labours are quicker; breech labours are often quicker), and did not expect this. We ate dinner and put my daughter to bed. At 10.40pm I woke up to a strong contraction. Finally!

My labour progressed straightforwardly with the support of Amy and Siobhan. 'Labour is labour,' said Siobhan. I spent most of my time kneeling and leaning on the arm of our sofa, moving from leaning forward to kneeling upright to trigger the contractions. Whenever I

Hannah emerges, hands off

turned over and sat back, my contractions stopped completely – had I been on a hospital bed, she would never have come out at all! At 5am I spent 45 minutes in the birthing pool and had a much-needed rest. Since the contractions reduced while I was in the water, I was helped out and they returned with a vengeance.

My midwives were hands-off throughout. They took me to the toilet regularly, watched, encouraged and waited. They did check the baby's heartbeat after most contractions, and were very apologetic that they felt this was necessary. They examined me only once, after I got out of the birthing pool, and that was at my request because the contractions were so powerful (I was fully dilated). Jane joined us in the room at this point.

Transition was truly rough. I could not stop thinking that I should have had a caesarean and that I had killed my baby by choosing a home birth. But my midwives and Ed held me steady, and I breathed through the contractions as they became stronger and stronger.

At this stage Ed recalls that Siobhan dimmed the lights and turned the heat up very high. In contrast, at my hospital birth, the lights had been turned up and extra strangers entered the room! I have no memory of this in either case – by this stage I was totally focused inwards on just myself and the contractions and my baby. Jane, Siobhan and Amy all watched intently, ready to intervene if needed, and supporting me with the warmth of their presence.

In contrast to my first birth, I could not feel the baby descending, which I found very disconcerting. By the time I did feel anything, she was already 'rumping'. I never actively pushed. I breathed (and shouted) through the contractions and eventually breathed her out. There was no 'ring of fire' (which I had found agonising with my first daughter). It took five minutes and several contractions from the first rumping to her being born, with a big stretch as her head came out. It was 7.05am. The labour had lasted exactly the same time as my first one.

No-one touched her until she was fully born. Amy caught her. She breathed straightaway. I had been warned that breech babies often need help to get started, so had expected her to be whisked away. Instead I picked her up. She was perfect and so, so tiny, and quickly gained a hat knitted by Siobhan. Miraculously our 19 month old daughter slept for an hour longer that morning than she had ever done before, waiting until her sister was safely born!

We had planned a physiological third stage, and the cord continued to pulse for over 20 minutes. Eventually the midwives asked if I intended pushing out the placenta – apparently the almost unnoticeable cramps I felt were contractions! So I pushed hard and out came the placenta, now buried under 'Hannah's rose' in the garden.

We named our breech baby Hannah Jane. Hannah is the same forwards and backwards. Without Jane and her skill and experience we would never have had the chance to bring her into the world so naturally and gently.

As a result of Hannah's birth I became a Trustee of Birthlight and set up the Breech Babies Club to support women like me. Despite that it took me over two years to be able to talk about her birth without feeling nervous and stressed. I was the 'amazing' woman who had had a breech baby at home. But we had gone against medical advice and standard practice, and ended up far away from the norm. It took me a long time to truly come to terms with that – we were far out on a limb, and if anything had gone wrong we would have been generally blamed for taking unreasonable risks, even though birth is birth and it doesn't always go smoothly.

In my mind I did nothing special – I was a healthy mother of a healthy baby and was fortunate enough to have a magical birth experience. It was the system around me that made it difficult, not the process of breech birth itself.

Amy Mokady
Birthlight Trustee & Founder of the Breech Babies Club
www.breechbabiesclub.org

A magical birth

Hannah

Are twins always high risk?

Joanne Whistler asks whether they are really a variation on normal

After a wonderful home birth with my firstborn, Oliver, in 2006 I felt confident in my body's ability to labour and give birth. Even when I discovered that I was pregnant with twins late last year I had the attitude that it was just a variation on normal.

It was only when I started reading up about multiple pregnancy and birth that my belief that I would have another good experience began to falter. Everything I read said that multiple pregnancies were higher risk, that I should expect a more medicalised experience of pregnancy and birth than a mother of a singleton, and implied that for my babies' sake I should give up any thought of what I considered to be a normal birth. Of course I wanted my babies to be safe, but I also wanted their entry into the world to be gentle and unmedicated – I was very aware of the risks and side effects of pharmacological pain relief and interventions such as induction.

In the end I had a fabulous home water birth attended by two independent midwives. My husband and a trusted friend were also there. My midwife monitored the babies intermittently and removed the caul from twin two's face but otherwise my labour and birth were completely intervention-free. In this article I will discuss the evidence base for management of multiple pregnancies and explore some aspects of planning the birth of twins or more.

A dearth of evidence

With my scientific background and working as I do in health policy, I naturally tried to read up on the evidence to help inform my choices for this pregnancy. What soon became clear was that research in many areas was sparse and often of poor quality. Multiple births are often excluded from mainstream studies, or are lumped together with singleton births. Twin-specific studies may not separate out pregnancies where the twins have separate sacs and placentas, those with one placenta and two sacs, and where the babies share both sac and placenta, despite the different risk profiles of each type of twin pregnancy. The biggest problem with the published research, however, was that in most cases it did not evaluate the options I was considering. One consultant obstetrician I saw said that from research currently underway we would soon know 'whether planned c-section or vaginal birth is safer for twin births.' No. We will know whether c-section or typical hospital management of vaginal twin birth is safer, but physiological twin birth in a place the woman feels safe with a trusted and highly skilled birth attendant will remain unevaluated. Research into other 'high risk' situations has been similarly flawed – the Hannah term breech birth trial[1] is a case in point.

Even when there is good-quality evidence, women need to be able to consider the research in the light of their own specific circumstances. For example, having twins put me at greater risk of pre-eclampsia than a second-time mum with a singleton pregnancy. However, my uncomplicated previous pregnancy meant I was less likely to develop pre-eclampsia than a first-time mum expecting a single baby.

With the patchy evidence base for management of multiple births, the process of making informed choices can be particularly difficult for an expectant mother of multiples. The rest of this article explores some ideas for thinking through the issues.

Avoiding complications of multiple pregnancy and birth

It can be empowering for the expectant mother to realise that she can reduce the likelihood of some of the commonly-cited complications of multiple pregnancy and birth. For example, pregnancy-related stress is associated with pre-term labour,[2] so after panicking in my first trimester I made a conscious decision to stay away from upsetting birth stories and articles. I also ensured I ate well, as insufficient weight gain in twin pregnancy is associated with pre-term birth and low birth weight.[3]

Before accepting an intervention, especially one with unproven benefits, mothers should consider potential iatrogenic complications. For example, artificially rupturing membranes (ARM) for twin two once the first twin has been born is a very common procedure, but the rush of fluid could bring the cord with it. Given that the presenting part may not yet be engaged in the pelvis, cord prolapse could result.

Understanding the risks, their likelihood and impact

The articles and books I read in early pregnancy that frightened me with their shroud-waving were frustratingly short on detail. They often simply said that multiple pregnancies were 'high risk' without specifying what those risks were, and used the 'high risk' label to justify why mothers of multiples should submit to interventions such as frequent ultrasounds and electronic fetal monitoring (EFM) without explaining how these interventions would reduce the risks. Those that gave more detail often mentioned complications such as premature birth and pre-eclampsia, but even then it was not at all clear how the interventions would help reduce risk. Discussion of the risks of the interventions themselves was almost non-existent. I really struggled to find information on the additional risks of a twin birth where the pregnancy was uncomplicated and term, which was information I needed in order to plan my babies' place of birth in the event of everything going smoothly. It is not acceptable for care providers to justify increased routine intervention by simply using the 'high risk' label. Women should ask what specific complications the clinician is concerned about, and how the proposed intervention will alter the likelihood or effect of these risks.

Many of the additional risks of multiple birth relate to things that can be dealt with reactively if they occur, rather than trying to pre-empt them. Attempting to do so may be counterproductive, such as repeated ultrasound scans to detect reduced growth.[4] In addition most potential problems would be extremely unlikely to lead to death or serious injury to the mother or babies. For example, postpartum haemorrhage is more of a risk in multiple pregnancies because of the larger placental site. However, should there be excessive blood loss in a physiological third stage, the opportunity has not been lost to administer drugs to contract the uterus and control the bleeding. Should this initial intervention not be sufficiently effective, further treatment might be necessary, but life-threatening blood loss in a healthy well-nourished woman is extremely unlikely.

With the 'high risk' label comes an additional reliance on care providers for information and guidance. The content and emotional tenor of this advice will be heavily influenced by the clinicians' background and experience. I saw two consultant obstetricians at two different Trusts and they were each concerned about entirely different aspects of my twin pregnancy! Nevertheless, the experience of talking to them was positive and I felt that they respected my right to make 'unusual choices'. I know this is not the experience many women have of maternity services. If the consultant is exerting inappropriate pressure on a woman to conform to hospital guidelines, some of the following suggestions may help:

- taking another clinician, such as a senior midwife, to any meetings with the consultant
- approaching the midwife consultant in normality at the Trust for support (if there is one)
- considering changing to a different consultant or even a different Trust

Creating favourable conditions for physiological birth

In all labours, the conditions that facilitate physiological birth are privacy, warmth, low light levels, upright and forward-leaning positions and avoiding activating the labouring woman's neocortex by, for example, asking her questions. These conditions are even more important for multiple births, but are less likely to occur. I asked a consultant obstetrician how many mothers of multiples laboured and gave birth in her hospital in predominantly upright positions. The answer: 'almost none', due to a combination of EFM and epidural use. There are often more people around during a multiple birth, and clinicians' belief that multiple births are high risk can create an atmosphere of fear. Michel Odent says of twin births:

'In general those who know about privacy as a basic need in labour are not scared by this sort of birth. It is the art of doing nothing. First you wait for the first baby. Then you wait for the second baby and finally you wait for the placenta. The point is to make sure that there is not too much excitation around after the birth of the first twin, so that the mother is not distracted and has nothing else to do than look at her baby in a sacred atmosphere. The same after the second one, while waiting for the placenta […]. Those who don't know about the importance of privacy are so scared of twin births that they create a cascade of interventions… if they have not chosen the easy way, that is to say a caesarean section. Today many practitioners are right to prefer a caesarean section. Giving birth without any privacy among scared people can be dangerous.'

Unless the woman knows who will attend her in labour and trusts that the midwife will create and support the conditions that facilitate normal birth, having a doula or other birth supporter to protect those conditions is likely to be very helpful. The woman's partner may find it difficult to support her through labour whilst at the same time protecting her birth space.

I was privileged to have had a highly-skilled team of independent midwives looking after me during my twin pregnancy and birth. My first midwife has extensive experience of breech birth (my twins were both vertex, but over half of term twin pregnancies involve at least one twin in the breech position), water birth and physiological third stage, and also experience of twin home birth. I had complete confidence in her skills, but also knew she would only intervene if truly necessary.

Can women under NHS care say the same things? Unfortunately not. Because of the very small number of women choosing (for example) vaginal breech birth and even physiological third stage, clinicians rarely get the opportunity to develop their skills and confidence in these areas. It is difficult for expectant mothers of multiples to choose physiological options if they cannot trust that the midwives and doctors are skilled in these areas. For example, inappropriate pulling on a baby during a physiological breech birth can be dangerous.

Minimising the negative impact of necessary interventions

Even when everything is in place to optimise a woman's chances of a normal, uncomplicated birth, it is important to recognise that complications can still occur and appropriate interventions can improve outcomes. Being prepared for the most common complications and interventions and planning for those eventualities can help a woman be and feel more in control if things do not go entirely to plan. For example, I was clear that if one or both of my babies were breech, I wanted to try for a hands-off vaginal breech birth. Should progress stall, however, I wanted a caesarean section rather than an attempted vaginal breech extraction, which I felt would be traumatic for both me and the babies. If I had ended up with a caesarean section in such circumstances I would have been disappointed, rather than traumatised as could have been the case if I had been bounced into a breech extraction.

Seek support

Being classified as 'high risk' can be a frightening and lonely experience. Women going through this in their pregnancy need support, but must take care where they seek it. It is very common to encounter the 'just do what the doctors tell you, what matters is a healthy mother and babies' attitude, even though it is not as simple as more medicalised = safer. The internet is particularly potent. I benefited from being able to talk to women who had experienced twin pregnancy and birth, and was

very grateful to friends who sent me links to inspiring twin birth stories and film clips. On the other hand I was scared to the point of tears by some of the 'information' I found on the internet and found venturing onto the TAMBA (Twins and Multiple Births Association) message board an extremely negative experience.

The future

The biggest stumbling block to 'high risk' women wanting low-intervention, physiological births is the deskilling of clinicians that results from the vast majority of 'high risk' births being very medically managed. Independent midwives on the other hand have opportunities to develop their skills and confidence in a wider range of births. It is hoped that independent midwives will be able to contract in to the NHS in future through the arrangements IMUK is seeking to put in place. It would be a huge step forward if women wanting a low-intervention approach to the birth of twins could be offered the services of an independent midwife on the NHS.

Joanne Whistler

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Birth of Pippa (twin two) in the caul

Jemima's long awaited birth

Georgina Lewis tells her story of the labour and birth that seemed never going to happen

We were very excited when we found, whilst backpacking in Africa, that I was pregnant and, based on the magic whirly-wheel, due on 23 August 2002. I was a little disappointed when two early scans moved my due date back to 1 September, but at least philosophical that this meant I wouldn't have to endure going overdue. Ha! Little did I know!

On our return to the UK I did a lot of research and we decided to book an independent midwife as I was very keen to have one-to-one midwifery care, as is normal in New Zealand (where I am from). Booking a home birth was a big step for us, and took a lot of soul searching, but all the research reassured us home birth was a safe, and potentially safer, place of birth for our baby.

After an uneventful, and indeed, pretty wonderful pregnancy, 1 September came and went and I was still pregnant. Days turned into weeks and still I was pregnant.

It was not an easy time. I couldn't face my antenatal class reunion knowing I would be the only one without my baby. Everyone wanted to know when we were going to be induced – friends, family, not to forget the lady at the supermarket!

However, an induction meant forgoing the gentle home birth that was really important to us. We were reluctant to interfere with 'mother nature' unnecessarily and expose our baby to the risk of a cascade of intervention. We took a lot of flak from some family members; some people made very thoughtless and upsetting comments. Others really came through for us, giving unconditional love and support and trusting our judgement. Again and again we searched our hearts and the literature for answers. Our midwife was superb, explaining all our options, visiting us far more than our contract required, and bringing colleagues to give much-needed second opinions. Importantly, she made it our decision; a seemingly rare occurrence in post-dates pregnancies.

In line with NICE Guidelines, we decided to attend our local hospital for checks. Scans and heart monitoring seemingly confirmed all was well, but the staff didn't make it easy. They were horrified at the length of my pregnancy and put a lot of pressure on me to book an induction, using emotional appeals and very little solid evidence. Oh, how I craved evidence-based research.

When it seemed that my body didn't know what to do, that maybe there was something wrong, the hospital checks were reassuring and, combined with three sweeps, helped us keep going. The internal examinations were useful because they showed that my cervix was slowly effacing and dilating, that indeed something WAS happening and there was a light at the end of the tunnel.

I wish I could say I was serene during the wait, but in fact it was a really tough time. Every day that passed it seemed less likely that labour would start. We never made a blanket decision to continue my pregnancy forever, just day by day we reassessed and agreed to carry on for at least another day, or until the weekend, or until Monday, and so on. In the meantime we tried seemingly everything to bring on labour, but our baby was determined to come when ready.

Finally, at 43 weeks and 6 days of pregnancy, I woke at 2am and felt a bit of periody-type pain. After 27 days of wondering, 'is today the day?' and being disappointed, I didn't take this too seriously, just went to the loo and back to bed. But as the hours went by and the loo trips increased and the niggling went on, I knew in my heart of hearts, this was it!!

At 5am I gave up trying to sleep and had a hot bath. I decide not to wake up Rob. Pains were coming every eight or so minutes, which seemed hopeful, but I wasn't getting any show and I was scared of being too hopeful that things were actually, finally happening. I was desperate not to ring the midwife too early, so instead went to cook myself a big breakfast, my stomach has always been a high priority for me!

At 7am I dropped a saucepan, which woke Rob who called out to see if I was OK. Too excited not to share my news, I went through and said 'I think the baby is coming today.' After 27 days waiting, Rob was not convinced. Declaring he wanted more sleep he pulled the covers over his head! Luckily I thought this was very funny. Something must have clicked, because five minutes later he wandered into the kitchen and asked, clearly in shock, 'do you still feel that way?' Indeed yes I did, more strongly with each passing contraction.

I finally spoke to my midwife at 7.15am. I was contracting every five minutes but finding it easy to cope. Having talked through a contraction she diagnosed prelabour, much to my disappointment, but told me to keep in touch. Huh! 27 days late and I'm only in prelabour! By 8.30 I was contracting every three minutes and when we talked again I said to her, 'Please don't tell me this is prelabour!' At this, she said, 'OK, you're telling me this is not prelabour, we're on our way.'

I was moving around the house and trying to maintain forward-leaning positions. I felt tired, but when lying on the bed found contractions very intense and hard to bear. I thought about my mother's three hospital labours a generation ago, when she was made to lie on her back, and felt very lucky.

The midwives arrived around 10.30am. It felt weird: I found their arrival an intrusion, even though I am very fond of them and had got to know them over the months. I felt a bit invaded and embarrassed, and was feeling quite introverted and private. As a bit of an extrovert I was surprised at my feelings, but so happy I wasn't going to hospital to be among strangers. My lead midwife came to

see me in the bedroom where I was pacing around, and then retreated to the sitting room to reorganise her day and give me the privacy and space I wanted.

Time passed in a blur, with things getting more intense. I couldn't stay mobile anymore, but was on my knees leaning over the bed. It was good to occasionally go to the bathroom and I tried a bath, but mostly felt good leaning over the bed. I had a TENS machine on, I found it a bit distracting trying to remember to hit the booster. Eventually I just turned it up, forgot about it and focused on breathing. I requested a VE at about 12pm and I was pleased to find I was 6–7cm dilated. Transition was not as bad as I had dreaded, although it was very intense. I remember talking about the benefits of an epidural and announcing this baby would be an only child! Throughout it all I felt in control and supported. I had asked not to be offered drugs and although it was intense, I always felt in control and safe. I was so happy I was at home!

At 2pm I began to feel bearing-down urges. I was mooing like a cow! After a while of pushing I felt concerned, I didn't feel like the baby had come down at all. A little while later I could definitely feel the baby's head in the birth canal for the first time, very exciting and a real morale boost. During this first hour of pushing the baby moved from right to left anterior without going posterior – all the leaning-forward positions worked!

It took an age for the baby to progress. I was aware of time passing and being tired. It also hurt a lot. I later found out that most of this pain was caused by a huge haemorrhoid. I had done birth preparation with a kit called the Pink Kit which had identified that I had a narrow pelvis outlet. We used some exercises from the kit to help me widen and I believe they contributed significantly to making the space for the baby.

Little by little the baby slowly dropped until finally I could feel it almost crowning. By this time I was working really hard with the pain and was discouraged by the feeling of the baby slipping backwards after contractions. I got the shakes and my contractions slowed. Throughout it all I was given unconditional support. I was encouraged to eat and drink and take a homeopathic remedy, which all seemed to help strengthen the contractions again. Meanwhile my poor husband was getting his hands crushed providing an anchor for me to push against!

The crowning of the head took a long, long time, and at this stage the midwives really came into their own. The head finally came onto my perineum with some position changes, but I was feeling so tired. I knew it was taking a long time and was feeling a bit desperate. I later found out from reading my notes that the head crowned for 17 minutes! The close monitoring of the baby alerted them to a drop in heartbeat and they helped me try another position so that it came up again. Suddenly, finally, I felt a 'give' and the head had been birthed. The next contraction seemed to take forever to arrive and I could hear Rob choking back the emotion as he saw his baby's head for the first time. Another contraction and with all my effort I felt the passing of shoulders and the long slithering body came out. What a relief!

The baby was passed up to me and I just lay on the floor looking in disbelief at her. It was such an amazing moment to finally greet this incredible creature whom we had waited so long for. Several minutes passed before we thought to look and discover we had a daughter.

It was so lovely to relax and enjoy meeting our baby in the glow of the late afternoon sun streaming through the bay window. The midwives were unobtrusive as they awaited the placenta. The cord stopped pulsating after 25 minutes, then we cut it. I had a relatively high blood loss but there was no panic; the midwives were vigilant and the bleeding stopped of its own accord.

After the birth, I felt ecstatic, but very tired and weak. The midwives did all the baby checks right beside me on the floor so I could see everything and help count her toes. Then they cleaned up and helped me wash and get into bed, then we ordered a fantastic feed from the local curry house. By 10pm Rob, Jemima and I were snuggled up in bed together, the midwives had tucked us in and left us to enjoy our first night together as a family. It was a very precious time.

In the days following the birth I felt very tender and I hadn't anticipated the complete mental and physical exhaustion that came with giving birth. I felt shattered and a little bit upset that the baby had taken so long to come and grown so big and made it such hard work for us both, but this feeling was quickly replaced by an incredible sense of achievement and empowerment.

We named our daughter Jemima Mary Elizabeth. Jemima means 'light of day', and the 'first' Jemima was the daughter of Job, whose faith was tested and rewarded by God in the Bible. Although it was an incredibly difficult time in the weeks that she was overdue, we feel so grateful that our belief in our baby and my body, and that she would come when she was ready, was rewarded.

Since Jemima's birth I have mulled over the length of my pregnancy. Research suggested the length of pregnancy is influenced by the father[1] and, sure enough, my mother-in-law confirmed all her babies had come at 42–43 weeks.

I am incredibly grateful to the wonderful midwives who believed in us. I feel certain that in hospital we would have had a very different outcome, starting with an induction. We feel so incredibly grateful that the midwives had the skill and confidence to support us to make informed decisions to get the birth we wanted. Since then I have met many women who have been told they can't have a home birth because they are overdue, or women who have had very traumatic inductions, with little information or choice offered to them, and I know that could have been me.

Two and a half years later, another beautiful daughter joined our family a mere 25 days 'overdue' and subsequently our son astonished us by coming only 10 days 'overdue'. The memory of their births is joyous and empowering and colours many aspects of our lives.

Georgina Lewis

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JOURNALS & BOOKS

AIMS Journal: A quarterly publication spearheading discussions on change and development in the maternity services, this is a source of information and support for parents and workers in maternity care; back issues are available on a variety of topics, including miscarriage, labour pain, antenatal testing, caesarean safety and the normal birthing process £3.00

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