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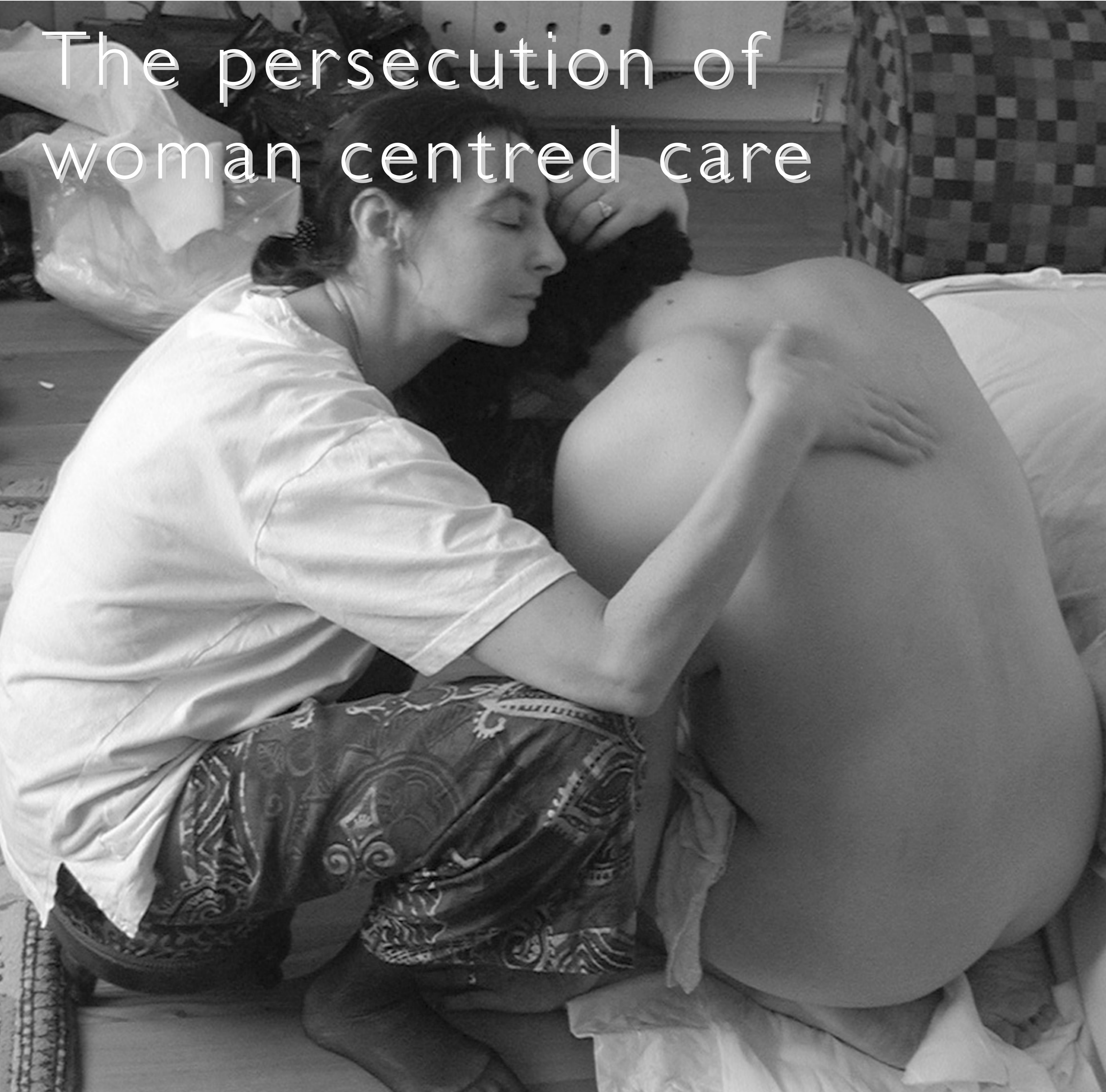

The persecution of woman centred care

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Founded by Sally Willington 1931 – 2008

The battle for control

Gill Boden asks whether we are winning the battle for control over women's bodies

In June this year headlines in the world's press reported that three times as many babies die in home births. This is because the American Congress of Obstetricians and Gynecologists published a meta-analysis of maternity and newborn outcomes of planned home births versus planned hospital births[1] on its website (www.ajog.org). It concluded that 'less medical intervention during planned home births is associated with a tripling of the neonatal mortality rate'.

This is not the case, and never has been, but wild claims repeated often enough tend to be believed: these headlines will be seized upon to confirm the prejudice of people who think that mothers can't be trusted to make decisions about their unborn children.

A whole series of influential and authoritative bodies immediately exposed the major flaws in this meta-analysis but the damage was done: another generation of GPs will be informing women that 'home birth is not safe' and obstetricians will be repeating that 'birth is only safe in retrospect'. On page 8 Beverley Beech takes a look at the meta-analysis and highlights some of the issues raised.

Added to this misreporting on home births are badly researched and inflammatory opinion pieces in the British press taking up the strain and discouraging choice without taking proper account of the facts, or even seeming much to care about them. Two prime examples from The Guardian and the Daily Mail are explored on pages 10 and 12.

Birthing at home with a skilled midwife has been shown to be safe and has numbers of advantages for women and babies. As AIMS' readers will know, unproven assertions that birth in hospital was safer than home birth had been largely accepted by professionals and public alike until statistician Marjorie Tew published her analysis of the risks of home birth.[2] Her analysis has never been refuted and further research has supported her findings. In 1992 a House of Commons investigation concluded that *'On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety.'*[3]

What is still unanswered is why the American Congress publicised Wax and colleagues' claims and why an editorial in the respected Lancet supported these claims,[4] when anyone with a smattering of understanding of research methods would recognise that this study was not in the least robust.

Even wilder media reports appeared in Australia where claims were made that home birth babies were seven times more likely to die during birth, based on a study where, as the authors themselves stated, *'small numbers with large confidence intervals limit interpretation of these data.'*[5] Nevertheless Andrew F Pesce, President of the Australian Medical Association (which is opposed to home birth), picked up this claim in an editorial accompanying the study and repeated it in his argument against home birth.[6]

When viewed in the context of the highly controversial closure of the Albany Midwifery Practice (see Margaret Jowitt's review on page 13 and the CMACE critique on page 5) and the current issues faced by women birthing at King's (page 4 and page 22), one must start to wonder if it is safety at all which is driving these attacks on home birth and midwifery care. It becomes all too clear in the plight of Hungarian midwife Agnes Gereb (see page 17), who has been jailed for simply supporting women's birthing decisions, that something other than the best interests of women has a controlling interest.

Amnesty International suggests more mothers are now dying in the US during birth than in perceived danger zones such as Bosnia. Clearly there are inequalities in life, care and perhaps in reporting. Why are more questions not being asked? Why has this not created the same level of press interest as the home birth debate?

However, birth does not usually require high levels of intervention in order to be safe. On page 20 Jo Dagustun writes about women who decide to birth unassisted by choice, rather than because they reject or cannot access care, and our book reviews look at how midwifery care could and should be. Page 19 contains a summary of the NCT's response to the government's NHS White Paper, *Equity and Excellence: Liberating the NHS*. Is this a golden opportunity for reform of the health service and a chance to improve access to flexible maternity care or a step towards privatisation and a reduction in service?

We could almost be persuaded that we live in a world of equality and rationality where women's decisions about their own bodies and lives are respected, unless, that is, we are aware of the backlash. In fact women's bodies and minds are still very much the sites of struggle. UK Government policy, based on the evidence, states clearly that women should be enabled to decide where and how birth but increasingly the right to home birth is being undermined by medical definitions of safety, for example in the recent Government White Paper on health. In actuality, women already have the unqualified right to decide and the strong resistance from the medical profession suggests that it is feeling under pressure. Our autonomy is enshrined in law and it is important that we retain that right.

Gill Boden

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Article

King's 'over-stretched'

The following article was run in the Daily Mail on 13 October 2010

Mothers forced to give birth in hospital waiting room where there was 'insufficient space to care for them.'

Women are being forced to give birth in a hospital waiting room because there are not enough beds in over-stretched maternity units.

Expectant mothers are going through one of the most agonising ordeals of their lives in a crowded seating area, while other patients look on.

Campaigners last night warned that such an appalling standard of care is putting the health of women and their babies at risk.

Over-stretched

Mothers were forced to give birth in public areas at King's College Hospital, which was running at 120 per cent capacity 'most of the time'.

King's College Hospital, in South London, has admitted that mothers 'regularly' go into labour in the maternity unit's waiting room as there are not enough beds.

Managers said the department is often so full that some women have their babies in the seating area – with nothing more than a temporary screen to protect their privacy.

The hospital admits the unit is severely over-stretched and there are not enough beds to cope with the increasing birth rate of the catchment area.

But critics warn that the dire situation will soon be commonplace up and down the country as increasing numbers of hospitals close their maternity units to save money.

In an internal report, managers at King's College Hospital state, *'Increasing demand for use of the maternity services at King's has resulted in there being insufficient space to care for all women appropriately when giving birth and accessing care.*

'Women are labouring in the waiting room on a regular basis while waiting for a labour room, sometimes giving birth inappropriately before this area is free.'

The document also reveals that in the past three months there had been 40 serious incidents at the hospital's maternity ward because there were not enough beds or staff.

Crammed

One woman who was giving birth at King's said seats had to be brought in from other areas for women who were having contractions to sit on

The hospital would not provide details of the individual cases but at worst they can involve the baby being seriously hurt during the birth, or even dying.

Earlier this week it emerged that at least seven NHS Trusts were planning to close or restrict their maternity units, which will mean nearby departments will become increasingly over-stretched.

Geoff Martin, the chairman of London Health Emergency, which campaigns against hospital cuts said, *'It is clear from this problem at King's that we don't have enough capacity for women in labour as it is. The problem will only get worse when more units close.'*

One mother, who did not wish to be named, said she had narrowly avoided giving birth in the maternity unit's waiting room because her labour was longer than expected. She said, *'It was ridiculous. I was kept waiting for hours, but luckily it was a long labour, so eventually I managed to get a place on the labour ward in time for the birth.'*

A spokesman for the hospital said:
'Like many other hospitals, our maternity unit is very busy – we deliver 6,000 babies every year.

'On very rare occasions, when women attended the unit in the very final stages of labour, they had to give birth in the waiting area because all the delivery rooms were full.'

Read more: www.dailymail.co.uk/health/article-1319801/Kings-College-Hospital-forces-mothers-birth-waiting-rooms.html#ixzz12iTTpB3w

Sophie Borland

AIMS Comment

AIMS is horrified to hear of women being subjected to 'care' like this in a hospital that has had 40 serious incidents in three months (2.7 per cent of its births). We are at a loss to understand how women giving birth could possibly be considered safer receiving care in this hospital rather than being looked after by the one–to–one midwifery service which was provided by the axed Albany Midwifery Practice. Surely many more group midwifery practices should be set up and fewer women should be going to under resourced, medicalised units. Surely every effort must be made to resist health cuts before serious incidents become ever more common place.

Articles like this also highlight how journalists condemning home birth use scaremongering, vengeful and accusatory language and speculate on unfounded dangers, yet those reporting on hospital examples of poor care tend towards down–playing the danger, and don't support the decision of the women who chose that care... Why does a safe choice cause an attack and the other seem perfectly acceptable to put ones self in danger?

CMACE

Nadine Edwards and *Sarah Davies* present a summary of their critique of the CMACE Report on the Albany Midwifery Practice

As we know, birth in most high income countries became increasingly medicalised and centralised during the nineteenth and twentieth centuries, particularly from the 1970s onwards. As we also know, a Conservative Government, concerned about these developments, published Changing Childbirth in 1993. This document emphasised the importance of midwifery care, keeping birth normal, and providing choice, continuity and control for women, preferably in a community setting. Further Government documents have reiterated this policy.

In response to Changing Childbirth a pilot midwifery project was set up in Deptford in South East London to put its aims into practice. This midwifery practice flourished for three years with excellent outcomes for mothers and babies, and was very popular with women and their families. When its contract with Lambeth and Southwark came to an end in 1997, a new contract was set up between the midwifery practice and King's College Hospital Trust, London. The newly named Albany Midwifery Practice moved to a community centre in Peckham in south London, where it was based until 2009. This contract was the first of its kind in the UK and was seen by many as paving the way for the maternity services of the future, in which midwives would be able to provide choice, continuity and control in a community setting. The Practice's outcomes continued to be excellent and the model of care provided by the Albany midwives was extremely popular with its local community. The Practice's contract was abruptly terminated by King's in December 2009 (See AIMS Journal Vol:21 No:3 2009 and AIMS Journal Vol:22 No:1 2010).

The contract was terminated without consultation with the Albany Practice midwives, or the local GPs who referred women to the midwives, or crucially with the women and families it served. To close a service without consultation is only permissible when carried out on safety grounds. Thus, on its website, King's states: *King's College Hospital puts patient safety before all other considerations. For this reason we have terminated our contract with the Albany Midwives Practice.* The Albany Action Group remains extremely concerned and puzzled by this statement and are calling on King's to withdraw it. The service has been evaluated on numerous occasions and outcomes have been shown to be exemplary.[1,2,3] For example, the Albany Midwifery Practice's perinatal mortality rate from 1997 to 2007 was 4.9 per 1000. This is lower than the national average and far lower than that of the local area as a whole, which was 11.8 per 1000 from 2004 to 2007.[4] Compared with other women in the area, women cared for by the Albany Practice midwives had a higher vaginal birth rate, higher intact perineum rates, lower episiotomy rates, a lower elective caesarean rate, lower induction rates, less use of pethidine and epidurals and a higher use of birthing pools. In addition the breastfeeding rates were exceptionally high, at around 80%.[13567] These outcomes were achieved in a population where many families are among the most disadvantaged fifth of the population of England. Women and babies in these groups are known to have the highest mortality and morbidity rates, as shown by the Confidential Enquiries into Maternal and Child Health (CEMACH).

The start of investigations

In 2008, King's claimed that proportionally more babies cared for by the Albany Midwifery Practice were suffering serious ill health at birth than other babies born within the King's service. A list of babies looked after by the Albany Midwifery Practice with poor outcomes at birth was put together, covering a 31-month period from March 2006 to October 2008. This list was revised on three occasions because of King's mistakes in the data collection, but nevertheless King's claimed that this list showed that the Albany Midwifery Practice's morbidity rate was ten times that of the Trust's overall.

it would be 'impossible to draw any inferences' from this data

Alison Macfarlane, Statistician and Professor of Perinatal Health at City University London and former advisor to CEMACH, has done a review of the list of cases compiled by King's. She concluded that it would be 'impossible to draw any inferences' from this data because of the incomplete nature of the data set.

The CMACE Report

Despite the concerns of the Albany Midwifery Practice that the data that King's was using was incomplete and misleading, King's commissioned an enquiry into the list of cases it had identified, in early 2009. The enquiry was started by CEMACH in early 2009, but the organisation became the Centre for Maternal and Child Enquiries (CMACE) in July 2009 and it is CMACE that produced a Report on the cases, called The London Report, in November 2009. The National Childbirth Trust, and others, produced critiques of the CMACE Report. AIMS produced its own critique because it was so concerned about how the enquiry had been carried out, the lack of details in the Report on which to judge the findings, and

how it had arrived at its findings, especially when these contradicted the findings of all the other analyses of the Albany Midwifery Practice mentioned above. For example:

- King's selected the cases referred to CMACE, and the selection criteria are not provided in the Report. We would have expected CMACE to recommend what data it needed in order to conduct an enquiry.
- The babies included in the enquiry were all born over a 31-month period. We thought that this time frame was very unusual, especially when it so happened that this 31-month period included two babies cared for by the Albany Midwifery Practice who had poor outcomes, one at the very beginning of the period and one at the very end of the period. Alison Macfarlane commented that, *'This time frame is not long enough to allow the possibility for time trends to be investigated. If the compilation of the lists was prompted by concerns that morbidity might be rising, then a longer series of data should have been compiled.'* Given the length of time that the Albany Midwifery Practice had been operating, it would have been possible to extend this period to a more appropriate length.
- The Report considered the care of a number of babies looked after by the Albany Midwifery Practice who had 'serious unexpected problems' at birth, but did not provide any context for these outcomes. In particular, the Report failed to mention that babies cared for by the Albany Practice (despite their all-risk caseload) had a much lower perinatal mortality rate than babies born under King's hospital care. Nor did it mention the overall excellent results of the Albany Midwifery Practice.
- The Report considered the care of 11 babies cared for by Albany Practice midwives, 10 babies cared for by other community midwives attached to King's, and no babies cared for by King's hospital staff. As well as a longer time frame for the enquiry, we would have expected similar groups of babies born at King's to have been included in the enquiry.
- The Confidential Enquiry's methodology which was used to assess the data was not appropriate for such a small number of cases. The National Patient Safety Agency recommends that for small numbers of cases, root cause analysis is a more appropriate methodology.
- King's diagnosed the babies who had been cared for by the Albany Midwifery Practice with hypoxic ischaemic encephalopathy (HIE): a diagnosis which suggests that babies have suffered lack of oxygen and subsequent brain damage during labour and/or birth. However, the National Perinatal Epidemiology Unit in England has strongly recommended that this term be replaced by the term neonatal encephalopathy (NE), as this describes the condition without assuming the cause.[8] This is because several studies and a review have suggested that NE is rare, occurring in only 2.5 per 1000 births, and that in approximately 86% of these, NE is due to antenatal factors rather than mismanagement in labour. The Report also failed to look at the longer term outcomes of the babies involved, although the National Neonatal Audit now requires a two-year follow-up for any baby diagnosed with NE. This is because while some babies with NE suffer long-term problems (some of which are very serious), some babies do not show any signs of any problems as they develop.

no problems associated with the midwifery care provided by the Albany Midwifery Practice

Interestingly, King's had already investigated the cases referred to CMACE through its own risk-management procedures and had found no problems associated with the midwifery care provided by the Albany Midwifery Practice. There is no evidence either that the midwives involved had been referred for supervision or had received any support as a result of any of the unexpected outcomes.

As we read through the Report it became clear that the data was viewed from a medicalised perspective and that holistic midwifery knowledge and care were not well understood, nor their benefits recognised.

We were also very concerned about the lack of understanding in the Report about women's abilities and rights to make decisions about their care, and a midwife's duty to support these. Although the right to make our own decisions about our own bodies is enshrined in law, and at the heart of Government policy, the CMACE Report appeared to suggest that this is not possible or desirable in practice and that women's decisions should be guided by practitioners following local policies and practices. Indeed one of the criticisms of the Albany Practice midwives was that the women they cared for did not always comply with King's guidelines. However, if women receive good information, they will each make their own decisions, which may on occasion fall outside local guidelines.[10] Midwives supporting these women should be applauded not punished.

Most of the Report's recommendations were about how to improve management failures. The Report did not recommend closing the Albany Midwifery Practice, but King's almost immediately terminated the contract with the Practice. We believe that, to date, King's has failed to address the management issues raised by the Report.

Developments since the CMACE Report

After the closure of the Practice, which King's claims was for safety reasons, all the Albany midwives were offered jobs within the Trust, and King's management stated at a public meeting that it had no concerns about

the midwives' practice.[9] In a subsequent letter to AIMS, in response to its critique of the CMACE Report, it became clearer that the main reason for closure was to do with King's inability to manage what it mistakenly considered to be an 'arm's length' body.

The impact of the closure continues to be felt very acutely by the local community the Albany Practice served. It is unusual for women to mount campaigns, yet within days, the Albany Mums was formed, and attracted in the region of 700 parents from the Peckham area and beyond. The Albany Mums Group has sustained a remarkably vigorous campaign, including organising numerous demonstrations, writing to and meeting with members of their Primary Care Trust who commission maternity services, contacting MPs, journalists and others, attending public meetings and consistently attempting to meet with senior staff at King's. The loss, both immediate and long-term, to the community cannot be overstated.

The closure of this service is striking at the heart of good midwifery

The closure also has national and international consequences way beyond the Peckham boundaries. The Albany Midwifery Model is a crucial benchmark for midwifery services and what can be achieved by excellent midwifery care. Not only does this model provide excellent physical and emotional outcomes for mothers, babies and families, it contributes to strengthening the community and improving health and well-being, is well liked by women and midwives, and is sustainable. The closure of this service is striking at the heart of good midwifery and what can be achieved through continuity, choice and control, even when women are suffering the impacts of poverty.

The Albany Action Campaign is supported by the Albany Mums, AIMS, the National Childbirth Trust, the Association of Radical Midwives, Independent Midwives UK, as well as many senior academics, statisticians, midwives, obstetricians and GPs.

We would appreciate your support, and would ask you to write to the Minister of Health to ask what steps he is taking to enable the Albany Midwifery Model to be established elsewhere in the area and also established in every Health Trust in the country.
www.info.doh.gov.uk/contactus.nsf/memo?openform

Nadine Edwards and Sarah Davies

To read a copy of the full AIMS critique, go to www.aims.org.uk/Publications/CMACECritiqueAIMS.pdf

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The NMC supports the right to birth at home

In March 2006 the Nursing and Midwifery Council published a circular explaining the current regulatory framework within which midwives practise. It states:

'Midwives may have some anxieties if there is a clash of a woman's choice versus the perceived risks of caring for women in a home setting. If there is a clash then the midwife must continue to give care but can seek support by discussing her anxiety with her supervisor of midwives.'

'Should a conflict arise between service provision and a woman's choice for place of birth, a midwife has a duty of care to attend her. This is no different to a woman who has walked into a maternity unit to receive hospital care. Withdrawal of a home birth service is no less significant to women than withdrawal of services for a hospital birth.'

NMC Circular 8 – 2006, 13 March 2006

Lies, damned lies and statistics

Beverley Beech explains more about the flawed home vs hospital birth meta-analysis

Over the years much of obstetric practice has been shown to be based more on opinion than research. Advising mothers to lie babies on their stomachs to sleep killed thousands of babies, routine episiotomy was shown not to prevent tears or infections, and consumer pressure forced change. Home birth, however, is another issue, and the small matter of good quality evidence seems of little concern to the American Congress of Obstetricians and Gynecologists (ACOG). Its enthusiastic promotion of the questionable and much criticised Wax, et al study[1] is the latest manifestation of its opposition. It so happens that the primary author, Joseph R. Wax, MD is Maine Vice Chair of ACOG. As Marjorie Tew has said, following obstetric criticism of her study, *'The threat of home birth is not a threat to mother and baby, but a threat to the healthy survival of obstetric and medical practitioners.'*[3]

In June ACOG published the on its website (www.ajog.org) the Wax, et al meta-analysis of maternal and newborn outcomes in planned home births vs planned hospital births.[2] The authors concluded that *'Less medical intervention during planned home births is associated with a tripling of the neonatal mortality rate.'* Needless to say, this claim was instantly repeated in the press around the world.

It is normal practice, when publishing a paper, to give various bodies a copy in advance so that they can study it and comment. However, ACOG was so keen to promote this study that it took a short cut and put it out on its website ahead of publication in September. This ensured that other experts had no opportunity to study the report and comment before publication.

A meta-analysis is a statistical analysis of the findings of relevant selected studies. It should establish strict selection criteria to enable a search of relevant papers which can then be combined and considered as a whole. It appeared that a substantial total of home and hospital births were available for analysis. Unfortunately, of the final 12 studies selected for inclusion, one study was too small to draw any conclusions (which the investigators admitted); one study found a higher death rate in the 'planned' home births (the researchers admitted that their findings may have included unattended home births that were not planned); one study was so old that one would have to question whether the findings would be applicable to modern maternity care; which leaves nine studies none of which supported the conclusions of the meta-analysis. Indeed, they all concluded that planned home birth carries no higher risk of perinatal mortality than planned hospital birth. Interestingly, the analysis managed to exclude the only large-scale prospective study of planned home births in the USA, which demonstrated that both women and babies cared for by Certified Professional Midwives had excellent outcomes.[4]

In their enthusiasm to inform the world of the alleged tripling of the neonatal mortality rate the researchers failed to mention that their own flawed meta-analysis found that women choosing home births have significantly better outcomes in every measure of maternal and neonatal well-being when compared with mothers having hospital births.

With commendable rapidity, following the ACOG publication, a whole series of influential bodies gave their comments, all of them critical, and the following is a selection of some of those comments:

'Unfortunately, the recent meta-analysis by Wax, et al .... is far from the high-quality rigorous review that health care providers and the public expect. Not only are Wax's conclusions in direct conflict with a growing international body of quality research that demonstrates the safety of home birth for low-risk women and their infants when attended by trained professional midwives, but his methodology is deeply flawed.'

Lawlor M,
National Association of Certified Professional Midwives

'Of the largest studies included in this meta-analysis, only three (Hutton, et al 2009; Janssen et al 2009; & de Jonge et al 2009) clearly distinguish between planned and unplanned home births. These three studies – which comprise 93% of the women included in the meta-analysis – found no significant differences in perinatal outcomes. Only one study (de Jonge, et al 2009) meets the gold standard for quality in home birth research and had sufficient numbers on which to base conclusions about neonatal mortality. This study found that babies born in planned home births were not more likely to die or to suffer severe illness in the first month.'

American College of Nurse Midwives

'Dr. Michael C. Klein, a senior scientist at the Child and Family Research Institute in Vancouver and emeritus professor of family practice and pediatrics at the University of British Columbia said the U.S. conclusions did not consider the facts. "A meta-analysis is only as good as the articles entered into the meta-analysis – garbage in, garbage out. Moreover, within the article, Wax et al did their own sub-analysis of the studies in the meta-analysis, after removing out-of-date and low quality studies, and found no difference between home and hospital births for perinatal or neonatal mortality. Yet in the conclusion, they choose to report the results of the flawed total meta-analysis, which showed the increased neonatal mortality rate." Klein said that this is apparently a "politically motivated study in line with the policy of the American College [now Congress] of Obstetricians and Gynecologists (ACOG) who is unalterably opposed to home birth."'

Simkins G, Midwives Alliance of North America

Comparing outcomes of home and hospital births is fraught with problems, and any study needs to differentiate between the different reasons women birth at home. These can be divided into women who:

- choose to birth at home with a qualified midwife
- birth in prisons or remand homes
- unexpectedly birth at home having booked a hospital delivery
- conceal or deny that they are pregnant
- are 'high risk' who refuse ever again to go into hospital
- choose to birth at home without any qualified attendant

It is hardly surprising, therefore, that so few studies take these confounding factors into consideration.

Despite the above criticisms of this paper The Lancet's editorial[2] claims that this flawed meta-analysis *'provides the strongest evidence so far that home birth can, after all, be harmful to newborn babies'* and goes on to say *'Women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk.'* It makes one wonder whether The Lancet editor even read the research. Is it any wonder that the public is becoming increasingly sceptical about medical opinion?

We expect medical professionals to be rigorous in their analysis of maternity care so that women can make informed decisions about the care they want. In the past the American Congress of Obstetricians and Gynecologists has appeared more interested in maintaining its control of maternity care than in the welfare of women and babies and, unfortunately, this study, and The Lancet's editorial, are further examples of its self-interest which will, no doubt, be quoted by obstetricians all over the world in order to continue to obfuscate the evidence and maintain their control of centralised obstetric care.

Beverley A Lawrence Beech

For the further details of the Wax meta analysis see AIMS website: www.aims.org.uk/Submissions/WaxMetaAnalysis.htm

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2. Pang JWY. Outcome of planned home births in Washington State: 1989 – 1996. This study, included in the meta-analysis, has received wide criticism for its conclusion that planned home birth is riskier than planned hospital birth. The study authors themselves admitted, *'This study has several limitations that are related to the reliance on birth certificate data. These include the potential for misclassifying unplanned home births as planned home births.'* In Washington state, birth certificates indicate the place of birth, but not the intended place of birth, and the qualifications of non-physician birth attendants were not determined for this study. Thus the study may have included unintended home births, or home births without a certified birth attendant, and is not appropriate for inclusion in the metaanalysis.

3. Shearer JM. Five year prospective survey of risk of booking for a home birth in Essex. *'The results of this study showed no evidence of an increased risk associated with home confinements but indicated that there were fewer problems than were encountered in the deliveries in mothers confined in hospital.'*

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5. Ackermann-Liebrich U. Home versus hospital deliveries: follow-up study of matched pairs for procedures and outcome. *'Conclusion: Healthy low risk women who wish to deliver at home have no increased risk either to themselves or to their babies.'*

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10. de Jonge A. Perinatal mortality and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births. BJOG 2009;116:1–8. *'This study shows that planning a home birth does not increase the risks of perinatal mortality and severe perinatal morbidity among low-risk women, provided the maternity care system facilitates this choice through the availability of well-trained midwives and through a good transportation and referral system.'*

11. Hutton EK. Outcomes associated with planned home and planned hospital births in low-risk women attended by midwives in Ontario, Canada, 2003 – 2006: a retrospective cohort study. Conclusion: *'Midwives who were integrated into the health care system with good access to emergency services, consultation, and transfer of care provided care resulting in favourable outcomes for women planning both home or hospital births.'*

12. Janssen PA. Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician. Conclusion: *'Planned home birth attended by a registered midwife was associated with very low and comparable rates of perinatal death and reduced rates of obstetric interventions and other adverse perinatal outcomes compared with planned hospital birth attended by a midwife or physician.'*

What The Guardian said

AIMS Chair *Beverley Beech* considers The Guardian's reporting of home birth

There was a time when one could rely on national newspapers' medical correspondents to analyse the results of medical research carefully. Not any longer. Too often newspapers, forever looking for a good headline, are only too keen to promote the idea that home birth is dangerous and hospitals are safe – no matter what the evidence. The Guardian's article 'Midwives attack hysteria over home birth' (16 August 2010) is a case in point.

Thanks to the flawed Wax et al meta-analysis, home birth, for once, became an interesting subject for the national newspapers. According to the journalists in The Guardian article, the issue provoked 'hysteria', when in reality it provoked informed criticism.

The Guardian quoted a Lancet editorial which stated that *'women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk.'* Nowhere in the article, in either The Guardian or The Lancet, was attention drawn to the sub-standard analysis in this research, although The Guardian's final paragraph did acknowledge the NCT's criticism that *'the researchers had used too small a sample size when looking at deaths and failed to distinguish effectively between "planned and unplanned" home births.'*

The Lancet was quoted as saying that it stood by its editorial which highlighted the work of researchers from Maine Medical Center in Portland, who had pulled together data from studies in the US and in Europe and considered a total of 342,056 home births and 207,551 hospital births. This gives the impression that this is a very substantial and authoritative study, when in reality the number of births actually included in the study is substantially smaller, and the majority of research papers used did not support the claims made by the Wax study.

the majority of research papers used did not support the claims made

Cathy Warwick, general secretary of the Royal College of Midwives, was quoted as criticising The Lancet, *'What shocked us about the Lancet editorial was its language and tone and how it pumped the hype about the dangers of home birth, and made sweeping and misogynistic statements' ... 'There is a danger that risk during childbirth is presented in a way which is leading women to believe that hospital birth equals a safe birth. It does not. There is no hard and fast guarantee that a woman will have a safer birth in a hospital than at home.'*

The Guardian also managed to repeat the standard obstetric chestnuts that *'home births can only be justified for about a "quarter of pregnant women" and the rising cost of medical litigation, with NHS obstetricians facing half a billion pounds of court fines, has made medics wary of the risks.' ... 'Disputes involving obstetricians, said Steer* [editor-in-chief of the British Journal of Obstetrics and Gynaecology and a professor at Imperial College] *now account for almost two thirds of the £800m NHS medical litigation bill. "That means 15% of maternity budget going to lawyers and clients. It has increased 10 fold in 10 years. Cerebral palsy victims get £6m each and I know private sector obstetricians faced with insurance premiums of £50,000 a year. I look after high risk women whose local hospitals will not take them on for delivery. And I have been up before coroners, ombudsmen ... even the high court. The money makes everyone want to play safe."'*

What Steer fails to mention is the fact that the majority of women going into large, centralised, obstetric units are fit and healthy and it is often those women who end up suing and little acknowledgement that 90% of this litigation involves obstetric mis-management, (one cannot sue unless one has a strong case of negligence) and a disproportionate amount of that takes place in hospital. This message perpetuates the myth that birth in hospital is safe and home birth is dangerous.

What the public had to say

What is so depressing is the level of ignorance of the British public and how successful the doctors have been in brainwashing the public into believing that hospitals are safe places to have a baby. The following, in italics, are some of the comments on The Guardian website:

'Parents should have the right to make an informed choice, and that choice should include everything we know about the various risk factors.'

Indeed they should, and it is time that parents were properly informed of the risks of hospital deliveries.

'I would like to see maternity units made as homely and as unlike a hospital as possible with opportunities for expectant parents to spend some time there getting to know the staff and the surroundings before hand.'

These exist, they are called free-standing midwifery units, and the Trusts are closing them down as quickly as possible, despite the fact that they are safer than large centralised obstetric units, have fewer interventions, better outcomes, and women and midwives prefer them.

'This is a complex question, hysteria on the basis of one paper (albeit a meta analysis) is undoubtedly bad.'

The criticisms are not hysteria; they are valid comments on a sub-standard paper.

'This is a simple demarcation dispute by people who fear irrationally that evidence based medicine threatens their jobs. They forget that the answer to a possible reality that home births are less safe than hospital births is not to sideline them, but empower them to make home births safer.'

This comment comes from someone who clearly has not read the research – had s/he done so s/he would see that the conclusion that home birth is less safe than hospital deliveries cannot be deduced from this particular research paper, and contradicts the conclusions of the majority of research papers used in the meta-analysis.

'There is a very real bottom line here ... when births go wrong they go wrong very quickly ... every first delivery is a sort of experiment ... if it doesn't go right the time taken to get too hospital may be too long for a good outcome.'

During the 1940s the first birth a midwife attended on her own was to a first-time mother at home. Why? Because it was considered that this was the safest birth of all – with first-time mothers there is usually plenty of warning of a developing problem giving ample time to transfer. Unfortunately, most first-time mothers are persuaded to have their birth medically managed in hospital and end up with a cascade of unnecessary interventions, then when those interventions lead to serious problems they are told that, 'If you had stayed at home your baby would have died,' when the reality is that had she stayed at home and not been subjected to those interventions she would most likely have avoided the problem in the first place.

'The main ingredient in all this is money ... the doctors and hospitals make a lot of money from the health care companies ... insurance companies'

Dead right: hospitals are paid more for a caesarean than they are for a normal birth which is one reason why the caesarean section rate has increased from under 10% in the 1970s to almost 30% today. See AIMS Journal Vol:22 No:2 2010 for a more detailed look at this very issue.

'I suspect most medics (who, by the way, are increasing[ly] female so hardly likely to be motivated by "power and control over women") are mainly concerned about avoiding damaged babies, which you'd think would be most people's main concern.'

Power and control are exactly what it is about, female obstetricians have to compete with their male colleagues and therefore often adopt a male philosophy. The medical profession itself claims that it is doing many caesareans to avoid litigation – this is highly unethical.

'The figures collated are from a wide and statistically robust set of studies.'

No they are not. Of the final 12 studies selected for inclusion one study was too small to draw any conclusions (which the investigators admitted); one study found a higher death rate in the 'planned' home births (the researchers admitted that their findings may have included unattended home births that were not planned); one study was so old that one would have to question whether the findings would be applicable to modern maternity care; which leaves nine studies none of which supported the conclusions of the meta-analysis.

It should be understood that the American Congress of Obstetricians and Gynecologists is a union and its primary objective is to control all deliveries, wipe out midwifery and never mind the evidence.

Beverley Beech

The Albany isn't the only one ... Braintree under threat

The Braintree birthing unit is still open currently but is in a discussion/consultation period about a new model of care for the Braintree area.

The proposal is that the unit will be moved to smaller accommodation in a different part of Braintree. In addition, the unit, which is currently staffed 24hrs a day, will be changed to being open from 8am to 8pm; outside these hours a woman planning to give birth at the unit will need to contact the on-call midwife who will then arrange to meet the labouring woman and a midwifery care assistant (MCA) at the unit to open up to allow her to access the labour rooms and birth pool/s.

Following the birth, the Trust proposes to discharge women back into the community between 2 and 4hrs after the birth with increased support from community midwives and MCAs or they can transfer to another midwife-led unit 15 miles away for a 24hr stay postnatally. This fast discharge represents a significant change to the current service where there are two double postnatal rooms to allow fathers to stay overnight with mum and baby after the birth and a number of postnatal beds on the postnatal ward – all of which will be lost if the changes are implemented. Local women have concerns over the discharge of women so soon after birth and have asked how this will impact on breastfeeding success for these women. If the new service does not meet local need, how long will it be maintained?

Women are relieved that at least they will have a birthing unit in Braintree still and that as a result of local pressure there will be two birthing pools in the new unit. However, overall the new model of care will represent a reduction in the number of midwives and MCAs serving the area.

The idea of reducing maternity services in Braintree seems preposterous given that Braintree has the highest birth rate across the catchment area and is a growing town where more housing is still being built.

The discussion period lasts until January 2011 although local women firmly believe that the decision has already been made and the consultation period is just window-dressing by the trust.

Lou Painter
NCT Antenatal Teacher, Braintree, Essex

Hull

AIMS has also heard that Jubilee Birth Centre in Hull is threatened with closure; more news to follow.

Attacking home birth

Beverley Beech highlights the ignorance of journalists reporting on home birth

The list of women journalists who write vicious articles about women who choose to birth at home is long. Reading their articles it seems that many of them had confidently planned and expected a normal birth, but ended up with a whole barrage of traumatic interventions, and fail to understand that their labour could have been entirely different had they had midwifery rather than consultant care. Whatever the reason for their experiences, instead of blaming the over-medicalised system and lack of resources they choose to target pysiological birth. Liz Fraser's article in the Daily Mail (19 August 2010) is a classic example.

Why is it that some women journalists feel the need to write hysterical articles and label people who decide to birth at home as foolhardy, selfish, reckless and almost any other pejorative adjective? Liz claims to be an authority on childbirth as she has had three children (all born in hospital with 'lovely doctors', and has written three books on parenting) and yet she criticises safe birth practices and seeks to deny women choices.

the complications were more than likely caused by the interventions

We are told that, *'two of my "low risk" labours ended up being more complicated than anyone had predicted. It was lucky I was in a hospital with immediate medical care available, or my babies could have been in real trouble,'* but we are not told what those labours were like (waters broken, drip set up, induction or acceleration, drugs for pain relief, epidural?) She fails to appreciate that the complications were more than likely caused by the interventions in hospital, carried out by those 'lovely' doctors.

She claims that 'even the teeniest increase in the risk of death to my unborn child, or to myself, would be more than enough to get me into my car and down the local maternity hospital the second labour started' but fails to appreciate that the claim that 'home birth is as safe as hospital birth' is only assessed on the numbers of deaths, it takes no account of morbidity, which is much higher in hospitals, making it often safer to have a baby at home than in hospital when the more common causes of illness are included.

Her article, of course, repeated The Lancet's claim that Wax, et al's meta-analysis *'indicates that home deliveries can double, or even treble, the risk of a baby dying during childbirth.'* She clearly had not read the study or, if she had, she woefully failed to understand it.

Perhaps what is most offensive about Liz Frazer's article is the assumption on her part that women are deciding to birth at home because they are selfish and unconcerned about their babies, when in AIMS' experience, women are exactly the opposite. Some of her more ignorant and offensive comments are:

'We're talking about the life of two people here – and, by association, the lives of everyone they know – and I value that ever so slightly above the need for comforting personal effects and my favourite CD on the stereo.'

'Where motherhood is concerned, exercising our "right" to have things exactly the way we want is potentially damaging'

'…where childbirth is concerned, I firmly believe we need to put our self-centred wishes aside, and be in the safest possible place just in case things go unexpectedly wrong.'

'The other selfish aspect of a home birth is that it requires a fully-trained midwife to leave the hospital and give one woman her undivided attention for the duration of her labour, which can be 24 hours or even much longer.'

Sadly these perceptions are common, but of course that does not stop women being encouraged into hospital on the dubious pretence of safety.

Beverley Beech

Quotation Corner

Twins

An obituary in The Telegraph (dated 24.11.10) of Margot Cooper (the first woman officer to land in France after D-Day) who has died aged 92, says that after the war she married an officer. *'Among their four children were the heaviest recorded British twins (10 lbs and 9 lbs 12oz) born in 1950.'* How much intervention would she have been subjected to now?

Compare the above with the advice below, given by an obstetrician at St George's Tooting who is, allegedly, an expert on twins:

'I can put you on a monitor for 23 hours and you could walk out of here and the baby could die at any minute' and *'Twin babies at 37 weeks are the same as a singleton at 42 weeks.'*

Needless to say, the mother who received this advice is looking for midwives to attend the birth.

Hypoxic ischaemic encephalopathy

Margaret Jowitt explains what this is and the clear bias of the audit of Albany outcomes

The investigation into the Albany Midwifery Practice began when the neonatal unit at King's College Hospital, London, noticed that babies born under the care of Albany midwives seemed more likely to be given a diagnosis of hypoxic ischaemic encephalopathy (HIE) than other babies admitted to the unit.

AIMS first learned of the cloud that was hanging over the Albany midwives in October 2009 and at the very first meeting of the Albany Action Group the midwives showed us lists of babies who had been diagnosed with HIE. The midwives were perplexed, their outcomes have always been excellent. They understood that the paediatricians were concerned about brain damage. However, they were also aware that some of the babies on the lists were now healthy toddlers and showed no signs of brain damage, although others had been diagnosed with cerebral palsy.

The Albany midwives contacted Alison Macfarlane of the National Perinatal Epidemiology Unit at Oxford University. She informed them that some authorities now considered the term hypoxic ischaemic encephalopathy to be outdated. Similarly, on its website, CMACE was calling for more research on neonatal encephalopathy, another term which includes HIE. I'd never heard of either condition and wondered what it was all about.

In a nutshell, HIE might be best described as signs of asphyxia at birth leading to brain damage which may or may not lead to a diagnosis of cerebral palsy, learning difficulties or developmental delay. Signs of birth asphyxia include very low Apgar scores, (table 1) and abnormal neurological signs including lack of muscle tone, seizures or coma.

Babies can be born 'flat' with no discernible heartbeat and making no effort to breathe. In common midwifery/medical parlance, a 'flat' baby is one who has no muscle tone after birth, is not breathing and probably has no heartbeat and needs neonatal resuscitation (Apgar 0–4).

Babies have evolved to be able to withstand lack of oxygen for a longer time than adults, fetal haemoglobin is better at carrying oxygen than adult haemoglobin and it is thought that a degree of asphyxia is the stimulus for taking the first breath. To some extent asphyxia at birth is physiological.[1] What matters as far as eventual outcome is concerned is the degree of asphyxiation and how long it persists.

Birth Asphyxia

Most ordinary people would understand that asphyxiation is caused by lack of oxygen. The pocket Oxford dictionary definition of asphyxia is 'suffocation', from the Greek meaning 'lacking a pulse'.

Newborn babies are given an Apgar score ranging from 0 to 10 at one minute after birth, at five minutes and sometimes at 10 minutes. Two points can be scored on each of five parameters:

	0	1	2
Skin colour/ Complexion	blue or pale all over	blue extremities	pink
Pulse rate	0	<100	>100
Reflex irritability	no response to stimulation	grimace, feeble cry or pull away	cry
Muscle tone	none	some flexion	Flexed arms and legs that resist extension
Breathing	absent	Weak, irregular gasping	Strong lusty cry

Table 1 – Apgar Score

Thorngren-Jerneck and Herbst in their study of a million births in Sweden between 1988 and 1997[2] state that the five minute Apgar score is more important than the one-minute score.

The anaesthetist Virginia Apgar introduced her scoring system in 1953, intended as classification or grading of the condition of newborn infants when evaluating the effects of resuscitation. Later, a low Apgar score became widely used as a proxy for asphyxia. A low Apgar score at one minute is often caused by a temporary depression, whereas low five minute and 10 minute scores usually imply complications of clinical importance, indicating that the newborn has not responded optimally to resuscitation.

Thorngren and Herbst quote a study in England[3] which found the rate of clinically significant birth asphyxia (post-asphyxic encephalopathy) to be 6 per thousand with no change in incidence over a 10 year period.

Warning signs for birth asphyxia include:

- fetal tachycardia
- late decelerations on the CTG
- scalp pH of less than 7.2
- meconium stained liquor
- poor response to delivery

Llewellyn Jones gives some iatrogenic causes of birth asphyxia: overstimulation with synthetic oxytocin and overuse of morphine analogues such as Pethidine.[1]

Hypoxic Ischaemic Encephalopathy

'Hypoxic ischemic encephalopathy: Damage to cells in the central nervous system (brain and spinal cord) from

inadequate oxygen. Hypoxic ischemic encephalopathy allegedly may cause death in the newborn period or result in what is later recognised as developmental delay, mental retardation, or cerebral palsy. This is an area of considerable medical and medicolegal debate.'[4]

Hypoxic means caused by hypoxia, lack of oxygen; ischaemic means 'caused by reduced blood flow' and encephalopathy means pathology within the head, or brain damage. Labelling a case as HIE does not state when any brain damage occurred. However, according to the website GPnotebook (www.gpnotebook.co.uk), HIE is used as a euphemism for birth or perinatal asphyxia, implying that brain injury occurred during labour or birth.

Medical terminology is riddled with Latin names used to maintain a professional distance between doctors and their patients. The website GP notebook reports that the term HIE is now used instead of birth asphyxia because *'it gives better information about what to expect'*. However, it does not give parents better information on what to expect! GP notebook suggests that HIE is a less emotionally loaded term in an era of high litigation. A cynic might suggest that, for the general public, re-labelling birth asphyxia as HIE obscures rather than elucidates, and indeed the reference to litigation tends to confirm this suspicion. If a parent is told the baby has a condition called hypoxic ischaemic encephalopathy rather than being told it has suffered birth asphyxia, the parent is likely to ask fewer embarrassing questions as to how and when the damage occurred.

It appears that HIE is virtually synonymous with birth asphyxia as far as the initial diagnosis from clinical observation is concerned, though strictly speaking there should also be evidence of brain damage (encephalopathy – pathology within the head) from MRI scan before birth asphyxia can be labelled HIE. The Hospital Episode Statistics still use the term 'birth asphyxia' to record the initial diagnosis of babies born with unexpected problems at birth and admitted to neonatal intensive care units.

Intrauterine hypoxia

Hospital Episode Statistics also give another code under which to record babies with neurological problems: intrauterine hypoxia. A baby showing neurological symptoms at birth may be suffering from damage resulting from an adverse event occurring before the onset of labour. Possible causes of intrauterine asphyxia include:

- maternal asphyxia – lung, heart disease
- poor uterine perfusion – shock, posture, vascular disease
- disease and separation of the placenta
- interruption of the cord, for example prolapse
- fetal anaemia and heart failure

Hospital Episode Statistics record more than five times as many babies diagnosed with intrauterine hypoxia as with birth asphyxia and six times as many in the latest year for which we have figures.

National figures HES codes P20 and P21

	2007–8	2008–9
P20 (intrauterine hypoxia)	**25,495**	**26,801**
P21 (birth asphyxia)	**4,248**	**4,020**

Neonatal Encephalopathy

The website for doctors, uptodate.com, describes neonatal encephalopathy (NE) thus:

'Neonatal encephalopathy is a heterogeneous syndrome characterised by signs of central nervous system dysfunction in newborn infants. Clinical suspicion of neonatal encephalopathy should be considered in any infant exhibiting an abnormal level of consciousness, seizures, tone and reflex abnormalities, apnea, aspiration, feeding difficulties and an abnormal hearing screen.

'"Neonatal encephalopathy" has emerged as the preferred terminology to describe central nervous system dysfunction in the newborn period. The terminology does not imply a specific underlying pathophysiology, which is appropriate since the nature of brain injury causing neurologic impairment in a newborn is poorly understood.'

(Uptodate.com describes itself as a website designed to give doctors and patients evidence-based medical information.)

What is the difference between HIE and NE?

The difference between these two terms seems to be one of medical convention alone. 'HIE' is a euphemism for birth asphyxia whereas NE includes both birth asphyxia and intrauterine hypoxia.

The financial problem facing the NHS is that if asphyxia during birth can be proved the hospital may be liable for millions of pounds' worth of damages for the lifelong care of a brain-damaged baby, whereas if the diagnosis says nothing about when and how that damage occurred, then the hospital can deny responsibility and fight the case in the courts, saving millions of pounds.

Cerebral palsy

It used to be commonly thought that cerebral palsy was the result of birth asphyxia but there is mounting evidence that this is not necessarily so. The incidence of cerebral palsy has remained constant even though more and more babies are born by caesarean section which is usually done at the slightest evidence of hypoxia during labour.

The Origins of Cerebral Palsy website says that it is important to diagnose the condition correctly:

'Before accepting a diagnosis of birth asphyxia, evidence is required of the presence of (1) hypoxia; followed by (2) decompensatory fetal response(s) indicating that the severity of hypoxia had exceeded the adaptive capacity of the fetus; (3) neonatal encephalopathy; and (4) a probable causal link between the encephalopathy and the hypoxia. This probability is enhanced if there is no evidence of a pre-existing neurological deficit.'

No one should presume a diagnosis of HIE until other causes have been excluded and criteria for HIE have been met. Until then, the only appropriate label – and one less likely to spark litigation – is neonatal encephalopathy, which may be due to a number of causes, many of which occur before labour and delivery.[5]

The King's audit of Albany 'HIE' babies

Hospital Episode Statistics show that countrywide, six times as many babies are diagnosed as suffering from intrauterine hypoxia as from HIE and yet whenever an Albany baby was admitted to the neonatal unit at King's College Hospital with signs of neurological damage, it seems the assumption was made that the damage was done during labour.

Under the Freedom of Information Act, AIMS obtained the audit which appeared to indicate that 42% of babies admitted to the neonatal unit (NNU) with a diagnosis of HIE were cared for by Albany midwives. Using my experience of clinical audit obtained as an audit clerk in a GP practice and with the addition of numbers obtained from the Albany's own records of babies born under their care, I was able to show that this audit was very far from an impartial piece of scientific research by a trained researcher, but the result of what looked like a very hasty effort by an inexperienced auditor to 'prove' that there was a problem with the care offered by Albany midwives.[6]

The very audit question itself was biased in three ways:

1. Timescale. The timescale of the audit was not scientifically 'sensible', 19 months and one day.

2. Length of gestation. It would have made sense scientifically to look at 'term' babies (gestation between 37 and 42 weeks, the normal definition of 'term') but the audit included Albany babies with gestation from 36 weeks + six days.

3. No consistently defined outcome. The audit was commissioned because it had been claimed that a high number of Albany babies admitted to the neonatal unit had a diagnosis of HIE, but instead of just considering babies with a diagnosis of HIE, any diagnosis of 'poor condition' at birth was included – and indeed another baby was included who was born in good condition and was admitted a few days later.

The auditor identified 458 babies who had been born near term and admitted to NNU. Of these, 48 apparently fitted the audit criteria. Here the audit criteria appear to have been changed because the reason for inclusion was now given as either:

1. Had a diagnosis of HIE (n=26 of which Albany 11)

2. In a 'poor condition' at birth, defined as 'required either prolonged resuscitation or other forms of invasive treatment' (no further details given) (n=22 of which Albany 5)

These criteria do not account for the inclusion in the analysis of at least one baby who was born in a good condition but admitted to the NNU a few days later.

From the figures given by the Albany midwives 34 Albany babies were admitted to the NNU in the timescale of the audit. It seems that 16 of these 34 Albany babies either had HIE or required prolonged resuscitation or other forms of invasive treatment whereas apparently only 31 King's babies admitted to the NNU had HIE or required prolonged resuscitation or invasive treatment. One wonders why 92% of King's 'near term' babies were admitted to NNU if they did not require any form of invasive treatment.

The whittling down of 458 'near term' babies admitted to NNU to 48 in the final group is the only part of the audit process which is amenable to statistical analysis because numbers are large enough for statistical tests. A simple chi-squared test between the number of cases included in the final sample from King's (31 cases out of 392 admissions, 8%) and the number of cases included from the Albany (16 cases out of 34 admissions, 47%) suggests that the selection of final cases was subject to gross selection bias ($p<0.0001$). One can only speculate about the babies who were left out of the final group from the King's sample. Some of these babies may have been given a diagnosis of NE instead of HIE – the incidence of intrauterine hypoxia is approximately six times the incidence of HIE.

Another indication of selection bias is the number of babies who died in each arm of the final group. We can assume that, having been admitted to NNU, care was similar for both groups of babies: those cared for by King's and those cared for by the Albany. Eleven of the 48 babies died, nine who had been born under King's care and two born under Albany care. This suggests either that Albany babies were better able to survive HIE or prolonged resuscitation than King's babies, or that the two groups were not comparable in terms of final diagnosis.

Conclusion

The audit purporting to show that Albany care was not safe is riddled with methodological flaws and reveals itself to be scientifically invalid through gross selection bias. It could equally have been used to suggest that babies born under Albany care were four times less likely to die of HIE than babies born under King's care. However, the most likely reason for the finding of a disproportionate number of babies suffering HIE is misdiagnosis. King's College Hospital chose to audit cases on the controversial diagnosis of HIE rather than the less subjective diagnosis of NE. It is difficult to avoid the conclusion that there may well have been a bias towards diagnosing Albany babies with HIE rather than the less accusatory diagnosis of NE well before the audit was performed.

Margaret Jowitt

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Southwark Council

The following letter was sent to the management at King's in support of the Albany Practice

Michael Parker, King's College Hospital Trust Board Chair
King's College Hospital NHS Foundation Trust
King's College Hospital
Denmark Hill
London SE5 9RS
15 July 2010

Dear Michael,

Closure of the Albany Midwifery Practice

At our recent 30 June meeting, Southwark's Health and Adult Social Care scrutiny sub-committee received a deputation regarding the closure of the Albany Midwifery Practice. This was requested by the Albany Action Group, comprising members from the National Childbirth Trust (NCT), the Albany Midwives, the Albany Mums Group, and the Association for Improvements in the Maternity Services (AIMS).

Representatives of the Action Group outlined their reasons for opposing King's decision to terminate the Albany Practice contract, and their hopes that the replacement services will emulate those that were closed.

This was not intended as a full discussion of the issues. It was rather to obtain an initial overview, so that we might decide whether to request further information and/or select this as a main issue for the sub-committee's 2010/11 work programme.

Having considered the Action Group's perspective and the input from KCH and the PCT, members agreed that we request as follows:

- that KCH reviews the statement on it website that the Albany Midwifery Practice was closed due to safety concerns, and considers whether it would amend this to refer to management rather than safety reasons;
- that KCH provide appropriate details about whether it responded formally to the AIMS and NCT critique of the CMACE report; and if this is not the case, whether it will now do so; and
- That KCH be encouraged to shape the new service so that it reflects the positive aspects of the Albany Midwifery Practice, as prioritised by local mothers.

Thank you in advance for considering our requests. I look forward to your response.

Yours sincerely,
Councillor Neil Coyle
Chair, Health and Adult Social Care Scrutiny Sub-Committee, Southwark Council

cc. Phil Boorman, Stakeholder Relations Manager, KCH

An encouraging development in IM UK's search for insurance

IM UK (Independent Midwives UK) is delighted to share the news that the RCM and the NMC have agreed between them to fund a proposed project from Roger Flaxman, an insurance specialist who has been working on the indemnity / insurance issue with IM UK and other organisations over the past couple of years. The proposal will investigate possible solutions to the lack of IM insurance and will include consulting with all relevant stakeholders.

Meanwhile, we are still awaiting the Department of Health (DH) response to the Finlay Scott review, which recommended that a requirement for indemnity cover should and could be linked to every health professional's registration. As there is currently no insurance available to independent midwives implementing this requirement would mean the end of independent midwifery.

However, para 140 – 144 (recommendation 20) of the Finlay Scott review identifies the root of the problem as 'market failure' and states:

'It is a well established principle that governments may need to intervene when the functioning of the market does not, or cannot, provide an affordable solution.'

Independent Midwives UK is hopeful that the DH, on behalf of the government, will accept this recommendation and will work closely with us and our stakeholders to develop and agree a solution as a matter of urgency.

Independent Midwives UK Board
4 December 2010

Jailed for being a midwife

Donal Kerry looks at the persecution of Hungarian gynaecologist and midwife Dr Agnes Gereb

Dr Agnes Gereb is an internationally recognised midwife and obstetrician who is the leading home birth expert in Hungary. For the last 30 years she has been responding to parents' needs for home birth and has done so in the face of considerable antagonism from the medical and political establishments.

On Tuesday 5 October 2010 Agnes was dramatically taken into police custody just minutes after attending to a pregnant woman who had unexpectedly gone into premature labour at her birth centre in Budapest. The mother had to be urgently transferred by ambulance to hospital with her baby boy when he displayed serious breathing difficulties immediately after birth.

The ambulance men reported Agnes to the police, who then arrested her and held her for 72 hours with access only to her lawyer. After the 72 hours in detention, she was taken before a closed criminal court and charged with *'reckless endangerment committed in the line of duty'* and remanded in custody without bail for a further 30 days. It is quite common in Hungary to spend more than a year in prison, awaiting trial. If found guilty, she could face imprisonment from one to five years.

From her pre-trial imprisonment on 5 October 2010, she did not see any member of her family until 2 November 2010. Even then it was only possible for her mother and one of her sons to visit for one hour, which leaves her eldest daughter and her two teenage children unable to visit her for at least another month. Agnes is subject to strip searches, is confined to her cell 23 hours a day, has been refused access to the library and medicines, and is permitted only 10 minutes of phone call time per week. Parliamentary representatives who wished to investigate Agnes's imprisonment were also denied access to her, despite the fact that Hungarian law guarantees parliamentary representatives the right to access all state institutions. Agnes appeared in court (on entirely separate charges already being processed by the criminal courts) wearing handcuffs and leg shackles that were so tight that she had a 10 cm gash on her leg. Even the judge presiding over her trial asked her guards whether these restraints were necessary, but he was told simply that *'it had been ordered.'*

On the 8 November 2010 the Hungarian Court Authorities ruled that Agnes should remain imprisoned for a further 60 days. They referred to the same two conditions for her continued imprisonment as cited when she was originally imprisoned. The two conditions are: the risk that she will repeat 'the crime' again and, the risk that she will destroy evidence and/or attempt to influence potential case witnesses.

How can a qualified doctor, a highly experienced gynaecologist and a trained midwife, who was responding to the urgent needs of a mother and her baby, be treated like this? And how can this happen in a civilised country, a member of the European Union?

The story of Agnes Gereb is the story of home birthing in modern Hungary. A story that shows how Hungary, since its return to full independence in 1990, continues to restrict free choice to its citizens in the hugely important area of childbirth. From the all-powerful Board of Obstetricians down to the local police, the Hungarian state has continually tried to force expectant mothers and their partners to give birth in hospital. But there have always been couples determined to choose their own way to birth and who needed to find someone who could help them fulfil their wishes. Agnes Gereb took on that role when, after 17 years of hospital service, she decided in 1991 to become an independent midwife. She was prepared to face the risk of heavy fines and imprisonment to help parents who decide to have their babies at home.

Now, nearly 20 years later and with over 3,500 healthy home births behind her, she still encounters incredible resistance within the Hungarian establishment to home birth. She has been struck off the doctors' register by a licensing body which dogmatically opposes home birth and, even before her detention, she and four midwifery colleagues were currently before the courts facing further serious criminal charges. Like all other independent midwives and the parents of home birth babies, she is continually exposed to levels of harassment and intimidation from police, ambulance and hospital staff whenever a woman planning a home birth has to transfer to the hospital system. Her arrest was the logical climax of a campaign of vilification and criminalisation which has lasted nearly 20 years and which clearly must have the support of a clique of obstetricians desperate to maintain their own power and earning potential from hospital birth.

campaign of vilification and criminalisation which has lasted nearly 20 years

Hungarian Law dictates that obstetricians must attend all births. This law ensures that obstetricians retain full control over birth, and, just as importantly, it allows them to continue maximising the incredibly lucrative (and untaxed) earning potential of hospital births. Obstetrics is one of the most lucrative branches of Hungary's supposedly free healthcare system, in which parents expect to pay up to a month's salary to the doctor who, according to law, must be present at each birth.

Also, Agnes Gereb's work is not restricted to home birth as she has long advocated for women who wish to escape over-medicalised, over-interventionist practices in hospital births. Her work proves that it is possible for Hungarian midwives to take on the role of main health-care professional at normal births. However, the current attack on Agnes Gereb through her arrest and gross mistreatment in prison leaves one baffled as to how any EU member country, signed up to protect the human rights of its citizens, could inflict or condone such humiliating and degrading acts to be visited upon Agnes. Complaints have now been lodged to the European Court of Human Rights about these violations of her human rights.

The persecution of Hungary's most experienced midwife in gentle, natural birth continues, despite a 1998 decision by the Parliamentary Ombudsman confirming that the Constitution affords mothers the right to give birth where they wish. But foot-dragging by successive governments has prevented any regulations from actually being implemented. As a consequence both the Hungarian Constitutional Court and the European Court of Human Rights are expected to rule against the Hungarian Government in the near future for failing to draw up and introduce the necessary regulations, and to order Parliament to do so without further delay.

In the meantime, citizens are exposed to the double-speak of a state which admits a mother's right to choose her home as a birth location, but prevents her from doing this on the pretext that the practical conditions for conducting home birth safely do not exist. By continually failing to introduce legislation to support the practicalities of home birth, the State has tried to remove home birth as a birthing choice for its citizens. However, many parents still insist on doing what their Constitution allows through the services provided by Agnes Gereb and a small band of independent midwives. These midwives have been refused the 'necessary' licences to operate legally, but are prepared to give their professional support to parents despite being under the constant threat of arrest and imprisonment for the services they provide to mothers in the home. Many Hungarian parents remain baffled and desperately saddened that the Hungarian State has yet again chosen to attack not only a true servant of the people but a highly ethical and professionally gifted doctor and midwife.

Hungarian parents have already held demonstrations against Agnes Gereb's imprisonment, one where they formed a chain of parents and grandparents from the Parliament to the Court, and further demonstrations are planned.

Donal Kerry
spokesman for the Free Ágnes Geréb campaign

For any further information or help in the above case please contact: Donal Kerry
(mobile) 0036309242190
email: free@birth.hu or visit our website: www.birth.hu

Obituary

Dr John Stevenson

5 October 1921 – 26 November 2010

On Friday 26 November 2010 Dr John Stevenson passed away after a six-month battle with cancer. He was able to stay at home up until the last two months and died peacefully with family at his side.

John Stevenson worked as a GP in a small town in Australia, and during his career attended over 2,000 home births. He became involved with home birth when he attended a woman who suffered from agoraphobia and wanted to birth at home. He noticed how much better the women and babies did when supported in their own homes.

He was known in Australia as the 'Father of Home Birth' and was a vigorous champion. He received the AIMS Journals and sometimes commented on their contents, and frequently wrote articles about his experiences assisting women to birth. His last contribution was a letter in response to an article by Colleen Walker (Vol 15, No 2, p8). He commented that 'After nearly twenty years in general practice, delivering hundreds of babies in hospitals, I didn't understand how a woman's emotional fabric is integrated into the birth process until (quite accidentally) I became involved in home births. It was a steep learning process in which I came to understand the intrinsic safety mechanism in-built in the mother and baby, and the process of labour.' He ended the letter by stating; 'Please, everybody, keep up the fight for decent, gentle, natural, safe birthing' (Vol 15, No 3, 2003, p13).

After many years trying to find women who would complain about his care, the Australian College of Obstetricians decided to strike him off the register, without ever speaking to him about his safety record or statistics, a record which, surprise, surprise, was far better than the local obstetric units'. He continued to attend women at home, but made it clear to them that he was no longer a registered doctor.

At the AIMS 50th Anniversary Luncheon on 16 October 2010, each table was named in honour of those health professionals who have been victimised by medical professionals antagonistic to their aims – one of those tables was named Dr John Stevenson.

Beverley A Lawrence Beech

Innovative and integrated

'In the Interest of Families: the Maternity Network Approach', *Gill Boden* summarises the report by the National Childbirth Trust (NCT)

The NCT has produced a thought provoking, positive response to the government's NHS White Paper, 'Equity and Excellence: Liberating the NHS', using the opportunity to make some well-argued points about the organisation and financing of maternity services.

The paper usefully reminds us of the ways in which maternity service users are different from most health service patients in that they are not usually ill; there is more than one individual involved; timing of birth is unpredictable; and maternity is a social and psychological event, not a medical one. It argues for a change in the way maternity services are financed: one of the most useful points made, I feel, is to explain how the present systems create a service that drives up the rates of intervention without improvements in maternal or neonatal outcomes, arguing that the current high–fixed–cost system leads to income–maximising behaviour, *'which means raising the volume and complexity of activity which then operates at the brink of capacity for financial reasons… this increases risk and damages the experience for users of the service.'* This is caused by full–to–capacity large obstetric units and a conveyor-belt experience. For example, Trusts are rewarded financially for high caesarean rates and staff tend to be drawn into hospital from the community to meet consequent staffing needs. The NCT paper suggests that what is needed is a high–variable–cost system rather than a high–fixed–cost one.

The White Paper states that maternity services will be commissioned by the new NHS Commissioning Board, and provided by the Maternity Networks; the NCT paper explains the likely make-up of each Network Board. Boards will employ midwives and ancillary staff and/or use independent midwives and lease in other services, possibly including obstetric services. Networks would be financed according to the numbers of women cared for and the complexity of care and thus incentivised to reduce both expensive interventions and postnatal complications. The NCT paper suggests that it will be *'strongly in the interests of the Maternity Network to make sure women have the care that will result in the lowest rates of medical intervention in birth but compatible with the best safety outcomes'*. This vision of the future of maternity services is a very exciting one. The NCT goes on to say that Networks would not be allowed to refuse to take on a particular case in order to avoid 'cherry-picking' the low–cost, and therefore profitable, simple cases, but I find it difficult to see how that can be avoided. At the moment Trusts are audited on providing a choice of place of birth for women and insist that they do so, but listening to women, we know, for example, that a home birth service is effectively withdrawn from women, often by discouraging them from that choice, so it is not difficult to imagine Networks discouraging certain users.

A diagrammatic representation of a Maternity Network shows four hospitals with maternity units, one birth centre and 14 scattered community midwives; this may represent present facilities but it is not clear to me how Maternity Networks could respond to what women want by, for example, opening new birth centres.

In order to set out a blueprint for the way Maternity Networks could work for the benefit of women and babies, the NCT apparently accepts the notion that competition between providers, in this case adjoining maternity networks, will improve standards. *'Successful Maternity Networks would have the opportunity to take on more maternity units covering a greater part of the population … by being able to offer better lease terms to the Trusts from which they lease services.'* While *'Maternity Networks that are badly run would shrink because they would not be able to cover their lease costs and their services would be taken over by the more effective networks.'* My concern is that 'success' may be measured in profit rather than care terms. The assumption is that each woman – with her partner – would be free to choose where she has her care. I think that the underlying assumption that competition will drive up standards is questionable particularly in rural settings. Furthermore, this argument has been used in the past when amalgamating hospitals; women were told that they could go to another, but the reality is that it is extremely difficult to be booked into another hospital.

One niggle I have with the language of this paper is the new orthodoxy that women must involve their partners with every aspect of the process of having a baby. While I am quite sure that most of the women who have partners want and get a large degree of involvement from them, it is women themselves who are pregnant and give birth, and they who make decisions about their own care: families are diverse and we shouldn't rigidly set out how women should go about the process of birth and learning about it, who they should talk to or proscribe who their birth companion/s should be.

If this proposal is to work then it is essential that the community midwifery part of this is commissioned by Public Health. In that way the maternity services will be able to flourish without the daily involvement of obstetricians. We have had 50 years of obstetric control of maternity care and this care is worse than it was 50 years ago when AIMS was first founded.

I think that the NCT response to the White Paper is an extremely helpful contribution to the debate. Its recommendations aim, among other things, to relieve acute Trusts from the responsibility of managing a service that is very different from their normal focus and that will almost certainly put maternity into a better place.

Gill Boden

What's right with freebirthing?

Jo Dagustun suggests how reflecting on the marginal pursuit of independent birthing can improve maternity services for all

What's the first thing that comes to your mind when you think about independent birthing (also known as unassisted birthing or freebirthing), where a woman prepares to give birth in her own home with support that excludes the presence of a midwife or other medically-trained person?

I was working with the issue of home birth when the media debate on freebirthing took off a couple of years ago, following the Channel 5 TV programme 'Outlaw Births'. Like most people, I had my doubts about freebirthing, but I quickly 'grabbed' what I needed from the debate: I concluded that this media coverage was an incredible opportunity for supporters of home birth. At a single stroke, it was possible to envisage home birth being shifted from the margins of birth practice into the mainstream imagination ('how middle-of-the-road and sensible to invite midwives to attend your home birth'). And mainstream it really is, given the very 'hospital-like practice' that – in my personal experience – too quickly seeps into NHS home birth protocols.

For many people interested in improving maternity services, however, the feeling that the issue of freebirthing primarily brings forth is a feeling of disappointment: 'it's a shame that the maternity services can fail so badly that some women will choose to give birth without their support'. It is seen foremost as a commentary on well-known problems in our maternity services: midwifery staff shortages, poor hospital facilities, the lack of time available to midwives to properly support women with complex psychosocial needs, pressures on a universal home birth service ... If such issues were resolved, the argument goes, a woman would have no need to opt out of the system in this way, risking her and her baby's health – as well as their lives.

But I would like to suggest that such knee-jerk reactions – reflecting more our existing agendas than the new information we have received – distract us from some important principles at the heart of the practice of independent birthing. We might pause, for example, on a key assumption generally made – but rejected by independent birthers – that on-hand medical support is vital for safe childbirth. Of course, midwives might be excused for making this assumption; indeed, the professional identity of midwives is in some sense closely allied to it. But we all know that it is perfectly possible to give birth, with good outcomes for mum and baby, without on-the-spot medical assistance. It happens frequently, whether planned or not (not least, of course, because of our peculiar insistence that women should travel during the late stages of labour).

Related to this is the way in which the practice of independent birthing forces a focus on the physiological, on the belief that female bodies are designed to give birth and that childbirth is an inherently safe, normal bodily function. The idea that women's bodies are strong and capable (as opposed to the culturally more dominant notion that women's bodies are frail and at risk of failure) is part of the rhetoric of the now-mainstream normal birth campaign, with its mantra that 'midwives are the experts in normal birth'. But – against a backdrop of our wider culture that insists on the devaluation of and domination over nature and the body – do enough of us really believe in this immense power and capability of the female body? Do you? Reflecting on our own attitudes towards independent birthing, I would suggest, can usefully provide a key to unlocking our personal and deep-seated attitudes, perhaps revealing less confidence than we like to assert.

need for a diverse and flexible range of maternity service workers

Furthermore, the practice of independent birthing might encourage deeper reflection on the role of the paid birth supporter. In any population of women, there are likely to be a range of different images that women hold of their ideal labour and birth support. One woman, for example, might see her ideal supporter as a medically-trained person who is present (perhaps in an adjoining room) on a strictly 'just-in-case' basis, for what is otherwise an undisturbed birth. Another woman, perhaps less experienced and less confident in her body's ability to birth, might welcome the reassuring presence of someone throughout her labour, to coach her as the birth unfolds and to remind her that her body is capable and strong. (This might not necessarily be a midwife, of course.) These ideas challenge the notion that 'a midwife is a midwife', and that the midwife – rather than the woman – is entitled to decide what support should be provided at any individual birth. All this engages with important debates about the need for a diverse and flexible range of maternity service workers to offer every woman truly individualised support during her transition to new motherhood, including some tough debates on the useful role of birth supporters other than midwives.

This is clearly linked to the way in which independent birthing powerfully suggests a necessary shift in the power relations between birthing women and paid birth supporters. Independent birthing can serve to remind us

of the intense taken–for–granted professionalisation of birth. But it really should be up to women – not the professionals involved – how, where and at what pace they want to birth. Too often we lose our focus on this key point as we repeatedly enact our familiar roles within a high-volume institutionalised service delivery machine. To enable women to claim power within a traditional birth setting is an immense challenge, and is a debate that gets us into difficult territory, given our observations that many women today seek to use any increase in power, perhaps paradoxically, to opt for a low level of personal autonomy within the birth-room and to seek a more medicalised route than many of us would think preferable for her or her unborn baby. But this again is something that needs to be tackled, rather than ignored, within the popular mantra of choice, and reformed antenatal arrangements would be a small step in the right direction.

We need to completely rethink our current approach which does little to encourage women to learn about and prepare for the incredibly powerful process of physiological birth, which is then too often overwhelming and [not] surprisingly 'like hard labour' for too many women 'in the moment', with the inevitable cascade of intervention that results. This would be an important element in a broader programme of cultural change aimed at restoring value to the practice of undisturbed physiological birth.

Whenever I come across an idea that seriously challenges my established ways of thinking, it often turns out that I have uncovered an unexpected opportunity for learning. By taking seriously some key issues raised by independent birthing – beyond those that simply support my own immediate agenda – my own deliberations have been immeasurably strengthened. As fellow members of the Association for Improvements in the Maternity Services, I hope yours will be too.

Jo Dagustun

Jo is a lay-member of AIMS, and is currently researching contemporary UK birth cultures for a PhD (based at the School of Geography, University of Leeds). Jo has four children, two of whom were born at home (supported by NHS midwives).

This piece was inspired by a recent PhD thesis on the topic of unassisted birth in North America by Rixa Freeze, which powerfully documents changes in professional practice made possible through an exposure to the phenomenon of independent birthing. Rixa's thesis is freely available online at rixarixa.blogspot.com

Ignoring Albany Mums

Beverley Beech reports on the continued campaign

Southwark Council has the right to investigate any significant health issue in their area and on the 30th June Southwark's Health and Adult Social Care scrutiny sub-committee, following appeals from the Albany Action Group, held a meeting to discuss King's College Hospital's unilateral decision to close the Albany Midwifery Practice on the spurious grounds of safety.

Emma Beamish, a founder of Albany Mums, outlined the reasons for the deputation of local mums, the National Childbirth Trust and AIMS, and explained that women particularly valued the quality of care provided by the Albany midwives. They looked after women throughout their pregnancies, during labour, whether at home or in hospital, and for 30 days after the baby's birth.

She pointed out that King's had terminated the practice's contract following the CMACE Report, which made a number of recommendations, but it did not recommend closure and to date King's has failed to explain just what the problems were. She felt that safety was used as an effective excuse because they did not need to consult with local parents and could terminate the practice immediately. In the meantime, the parents had been left with little information or support; and were expected to accept the standard care on offer which was in no way comparable to the service they received from the Albany midwives.

Anne Fox from the National Childbirth Trust (NCT) explained that the NCT had become involved in this issue because the Albany Practice offered a gold standard of care, had superb outcomes, had received national and international awards, and was a model that should be copied across the country. She added that the NCT had asked King's to change its website statement (see page 5) as problems related to management issues not safety.

Sally Lingard, associate director of communications and marketing at King's, was questioned by the council members and claimed that the EU working time directive made it difficult for the midwives to be on call 24/7 but they were recruiting for a replacement practice that would offer this service; and added that if women wanted a home birth they would be supported.

The council members also wanted to know why King's had offered to employ the Albany midwives when King's had claimed that the service had been withdrawn due to safety concerns. Sally Lingard waffled and left everyone bemused as to whether it was the model or the midwives who were considered by King's to be unsafe. She commented that the formal statement on King's website refers to patient safety.

The deputation asked the sub-committee to scrutinise the process by which King's had reached its decision to close the practice, including the evidence on which the decision was based.

Southwark Council's response is on page 16.

Quality care and double standards?

Caroline Kidd shares her experience at King's College Hospital

King's antenatal midwifery service was impersonal, short staffed and offered no continuity. I saw a different midwife on every occasion, received no helpful answers to any of my basic questions, and felt that none of my concerns were ever addressed. Appointments were very brief (none lasted more than ten minutes), so there was no time for meaningful discussion about any issue.

When I attended sonography appointments at King's no member of staff ever introduced themselves properly. During my first scan I had to answer a number of questions asked by a staff member who sat at the computer with her back to me, did not make eye contact throughout, or make an effort to introduce herself to me or my partner.

A transvaginal ultrasound was interrupted by two male doctors who wandered into the room unannounced leaving the door open to the hallway behind them. They ignored me and my partner, failed to apologise for the intrusion, and announced that their consultant needed the room.

I experienced equally poor practice in the Maternal Assessment Unit which I attended with abdominal cramps and I spent seven hours waiting to be seen. They were very busy, and short staffed, but no attempt was made to communicate the problem to anyone. There was no air conditioning in 90 degree heat or access to water, or indeed enough seating for two hours. Two very unwell women were lying on the floor, one of whom was in active labour, and this seemed more reflective of a third world health care system than an NHS clinic. In addition to this, there was no respect for confidentiality.

So, six months into my pregnancy, I decided to swap to the Albany Midwifery Practice. I had been attending their antenatal groups and had been really impressed with their knowledge base and their obvious commitment to the women and babies under their care. I waited for a space to come up. There was a long waiting list, which I think reflects the popularity of this model of care. I was so delighted and reassured when Danielle and Mary took on my care because I had had such a poor experience at King's. I immediately felt very well supported. Danielle and Mary visited me at home and helped me put together a birth plan of my choosing. This was so empowering, as King's midwives had told me that home birth was not an option due to my age (40). They also involved my partner and gave him a lot of support too. We were supported as a family, which was really important to us.

Over time, I felt that we formed a really close bond with Danielle and Mary and they became like friends, as well as wonderful professionals. I was looking forward to my home birth, but three weeks before my due date King's pulled the plug on the service. At this late stage, this was devastating and caused me and my partner so much distress. I lost all confidence in being able to cope in labour without Danielle and Mary. I was offered the option of switching to Brierley if I wanted a home birth or going into King's. I didn't want to meet a stranger at this late stage and I also didn't want to collude with the negative assessment of the Albany midwives by swapping.

The Albany midwives continued to offer me as much support as they could through all of this, but were limited greatly by being very short staffed and by the limitations King's imposed on them. In November last year I went into labour, but because King's had unilaterally closed down the Albany Practice, on the spurious grounds of safety, I was admitted to King's College Hospital and I ended up with one of the most traumatic experiences of my life.

My waters had broken at 02.00 and when examined at 09.00 I was found to be only 1cm dilated and was told that I would be admitted to the Nightingale 'Birth Centre' for induction as my waters had broken some hours before and my baby's heart rate was raised.

When I arrived at the 'Birth Centre' (a pseudonym for labour ward) no-one knew I was coming and I was left in a room for two hours without any contact from a midwife and no pain relief, despite being in significant pain and distress. I had been suffering a very painful back labour for two days and nights and had had no sleep. Eventually, I saw a midwife who said that I was only in early labour and offered co-drydamol and suggested that I go home or 'walk to Nando's and have a glass of wine' as this would relax me.

Worried by the report of my baby's raised heartbeat I accepted two co-drydamol and went for a coffee in the hospital restaurant. During this hour the pain worsened and the contractions were coming every three minutes. I returned to the ward where I was told that if I did not want to go home I could have IV pethidine and antibiotics and stay the night on the antenatal ward. In desperation, I agreed. This was now the third night in labour. I was having contractions every three minutes and a vaginal examination at 04.00 revealed that I was still only 1cm dilated. I was given a suppository to induce labour but it gave me diarrhoea and increased pain. At 09.00 a doctor arrived and proposed further induction and when I asked for pain relief I was told in a very patronising manner that I was only in latent labour and pain was a normal part of the birthing process. It took until 12.00 to find a bed on

the labour ward where I was left alone for three hours without any pain relief or even a glass of water. A midwife then appeared and asked if I would agree to be filmed for a training DVD for the staff! I agreed in the hope that I might get some badly needed support and pain relief. Instead I was filmed having my blood pressure taken three times and still did not see another midwife for a further hour. I was told they were short staffed (but apparently not so much so that they couldn't recruit patients for the DVD) and was finally offered the induction and an epidural 30 hours after my arrival at King's. It was during the scan, prior to the induction and epidural, that it was finally realised that my baby was an undiagnosed breech, despite two internals and eight examinations.

At 16.07 I had an emergency caesarean operation. The spinal anaesthetic caused a high block, my blood pressure crashed, I had breathing problems and uncontrollable shaking. I feared for my life and was given so many drugs that I became very sick and disorientated and cannot remember the delivery at all. I literally lost the first six hours of my daughter's life. Most distressingly, I was unable to hold my baby, feel the skin–to–skin contact or feel her breastfeeding. My partner had to hold the baby to my breast to enable her to feed. This has continued to affect my bond with my daughter and set up breastfeeding problems that resulted in my having to swap to formula feeding six days later. It was devastating for me as I was totally committed to breastfeeding.

I was transferred to William Gilliat ward still unable to feel any of my upper body, including my face, so I needed a lot of help feeding the baby who was very unsettled during the night. Eventually, a midwife who was not prepared to assist me with breastfeeding took Jasmine to SCBU and fed her someone else's breast milk. She didn't have my consent for this. I was told there was no choice as 'I was unable to feed her', despite the fact I had already done so several times. In the morning, I asked a nursing auxiliary to help change the baby as I still could not feel my legs properly. I was told to do it myself on the bed. A midwife arrived and commented that my baby was very big and had I overeaten all through my pregnancy or had I been feeding her too much since yesterday!

I contacted my Albany midwife to help organise my discharge. So less than 24 hours after a caesarean operation, still feeling very unwell, I left. My concerns about the dreadful 'care' I received and the ignorant comments were relayed to the ward manager who said, 'I hear things like this all the time, what can I do?'

Unfortunately, four days later I was re-admitted with a wound infection and then lectured on giving up breastfeeding. I needed daily wound dressing that frequently took up to three hours every day due to midwives not feeling confident to dress wounds (their own words) and their failure to order the appropriate dressings recommended by the tissue viability nurse. I was discharged four days later having taken all day to get the required wound dressings as the staff had failed to complete the paperwork.

A week later I was re-admitted through A&E and the staff there were absolutely wonderful but, once again, on the gynae ward I had yet more poor care. The nurse refused to do my dressing prior to discharge and told me to leave it open to the air or do it myself and told me to get the district nurses to do it when I got home. Allegedly, they did not deal with dressings on this ward.

I eventually taped up the dirty dressing and, not surprisingly, felt traumatised and depressed by my experience. I took anti-depressants, and in my letter of complaint I stated that I felt that I was the victim of mismanagement and emotional abuse at King's College Hospital and this has put me off ever having another child. The Trust did not even acknowledge my complaint until I had chased it up through PALS [patient advocacy and liaison service] a month later. Still not having received a response two months after that, I wrote asking for a meeting and threatened to go to the Ombudsman if the complaint was not dealt with.

At the complaints meeting, the Head of Midwifery, Katie Yiannouzis, expressed her concern about the treatment my husband and I received and when we told her of the worst examples of poor treatment and attitudes of one particular midwife (the one who took Jasmine to the SCBU and fed her without my consent) she apologised, assured me that she would be taking this up with the midwife (whose behaviour was known to her), but then added, 'but midwife xxx will be retiring soon'.

The loss of the Albany Midwifery Practice is a tragedy for women and babies, and I fear women will continue to have horrendous experiences like mine unless the value of this model of care is understood and this wonderful service reinstated.

Caroline Kidd

AIMS Comment:

King's agreed to pay for a psychotherapist to help Caroline with her post traumatic stress but, to our knowledge, Katie Yiannouzis has taken no action to report the midwife named in Caroline's complaint to the Nursing and Midwifery Council, despite having heard previous examples of this midwife's sub-standard care. This is yet another example of double standards, when Katie Yiannouzis has reported award winning Albany midwife, Becky Reed (who has an exemplary reputation) to the NMC.

Albany Mum Caroline Kidd and baby Jasmine

Reviews

Midwifery Continuity of Care: A Practical Guide

by Caroline Homer, Pat Brodie and Nicky Leap
Churchill Livingstone 2008
ISBN: 978-0729538442
£29.99

It seems particularly ironic that just as midwives in Australia are forging ahead with continuity of care models, in the UK, the flagship of midwifery continuity (the Albany Midwifery Practice) has been closed down by King's College Hospital amidst an outcry from the local and wider community (as is clear in this and previous AIMS Journals).

This excellent book, edited by three midwives who have worked tirelessly and effectively to improve care for women, is inspirational. The preface, written by UK midwife Tricia Anderson during the last year of her life, encapsulates why a trusting relationship between the woman and her midwife is the bedrock of safe, positive birth for women and midwives. Tricia describes her epiphany: 'My epiphany came one day when I met a woman in the supermarket with a toddler who said, "Hello, don't you recognise me. You delivered James ..." and I had absolutely no memory of her at all'. Tricia's poignant stories about deep engagement, listening and sharing show clearly and simply how relationships based on trust build in emotional safety for the woman which increases physical safety for mother and baby. For example, one story tells of a woman and her partner who felt so damaged by their first birth, in an institution among strangers, that they avoided antenatal care during their next three pregnancies. Meeting Tricia and establishing trust enabled them to receive care late in their fifth pregnancy, through birth and postnatally. All Tricia relates is supported by the chapters in the rest of the book. It seems that all women and families can benefit from being cared for by a known, trusted and sensitive midwife, but for some families it is vital for them, in order to avoid damage through birth, or further damage following previous trauma or other disadvantages.

As the title suggests, this is a very practical book, covering the meanings of continuity of care and what we know and don't know about its impact on families and midwives, how to provide caseloading care and other models of continuity in urban and rural settings, what midwives need to sustain these ways of working, setting up caseloading in the community and in large maternity units, working for change with midwives and obstetricians, costing midwifery continuity models, how to better evaluate continuity of care models, and working politically for widespread change in maternity systems.

One of the problems cited in the book is that the importance of knowing and trusting a midwife has been undermined by this becoming a 'choice' issue, rather than valued as a component of safe, effective midwifery care: '...knowing would give a depth of clinical care that would enhance assessment and increase safety, not only physical safety but social safety' (p35).

Another problem is around how services are costed: 'our services are set up to only manage short term costs. The longer term implications, including less morbidity, increased breastfeeding or lower levels of distress are usually not factored into the costs of the service as these are not directly impacting on anyone's "cost centre" or budget' (p39). This lack of overview is surely anathema in a world of decreasing resources.

A further obstacle often cited is that of sustainability for midwives. Yet, what we do know suggests that appropriate caseloading is more sustainable for midwives than team midwifery models, and that this is largely to do with levels of control and autonomy, and social support at work and at home.

All the chapters are fascinating, relevant and helpful. Highlights for me are the chapter by the three editors on bringing continuity of care into mainstream maternity services, and the chapter by Christine Cornwell, Roz Donnellan-Ferandez and Anne Nixon about bringing midwifery group practices into a large maternity hospital. At the time of writing, these groups were providing care for 1000 of the 4600 women, regardless of risk. It is extremely heartening to see that this can be and is being done, with excellent outcomes.

Leadership is of course vital: 'Woven through [the] chapters are subtle and not so subtle messages about the vital role that leadership plays in making change happen, bringing people along with the change and making the changes acceptable to the majority of stakeholders across the service' (p163). As we know well at AIMS, the value of midwifery leaders with a 'can do' philosophy cannot be overstated.

A chapter by Barbara Vernon from the Australian College of Midwives stresses the importance of being political and taking every opportunity to promote midwifery and raise awareness of its enormous potential contribution to improving public health.

The editors bring the book to a close by discussing how we can develop midwives for the future: 'We need midwives who are competent and confident with clear vision, political consciousness, energy and passion. We seek an independent and collective self-confidence that will see us through the labour of developing new systems and into the ultimate achievement of giving birth to midwives, managers, organisations and health systems that embrace midwifery continuity of care' (p 218).

Hear, hear and the sooner the better.

Nadine Edwards

The Midwife Mother Relationship

edited by Mavis Kirkham
Palgrave Macmillan 2010
ISBN: 978-0230577367
£22.99

This is one of the best childbirth books I have read. Without a doubt. This is a book about what it means to be a midwife, and what it is like to be cared for by a midwife able to be truly with woman. I would recommend it to anyone and everyone interested in making birth a wonderful and empowering experience.

Every page is filled with empowering and supportive thoughts and language and every chapter is written by someone who has inspired me, people such as Nadine Edwards, the late Tricia Anderson, Ruth Deery and Billie Hunter. This book contains a huge amount of information, yet remains an accessible read, it is well referenced and provides a huge resource for further study too.

The book opens with a thorough look at maternity services and explores the political context and the organisation of the system alongside the concepts of normality and safety. It introduces the thought that the relationship between midwife and mother should be two way and is of vital importance for successful care.

Chapter two, 'The less we do the more we give' by Nicky Leap, is simply wonderful. Nicky tells us that midwives need to believe in women, even when it seems like the odds are stacked against them, and more importantly that confidence must be communicated clearly to the woman. She also stresses that 'our expertise as midwives rests in our ability to watch, to listen and to respond to any given situation with all of our senses.' This is holistic midwifery at its very best.

My personal favourite chapter is the fourth, where Mary Cronk explores the concept that a midwife is a professional servant, employed by the woman (either directly or indirectly) to care for her. Mary asks us to remember that anyone providing a service is a servant, that a midwife has a profession, and that therefore a midwife is a professional servant, like it or not. Mary challenges midwives to free themselves of the notion that they have power over those they care for, to stop 'letting' and 'allowing' because she explains that a midwife has no right to 'presume a power' or to 'use that power to control women.' What this chapter does wonderfully is to explore the real role of the professional servant, and look at the historical and political context which encouraged midwives and women to forget that the relationship is one of a woman employing a midwife to care for her, and shifted the power from employer to employee.

Mary argues very convincingly that the root of so many unsatisfactory midwife-mother relationships is a situation where employee is ordering employer about. It simply doesn't work, and those midwives who build successful relationships are those who, consciously or subconsciously, gently empower women to make their own decisions. Mary goes on to explore the issue which is often used as an excuse for retaining power, that some women 'want to be told what to do.' Mary suggests that this is because they expect to be directed and they may not be used to having their opinions even sought, never mind valued. Some women may even find not being told what to do quite threatening because they have no idea how to do otherwise in such a situation... However, rather than the common solution of assuming control, Mary encourages midwives to use sensitivity and to support the woman to increase her decision making and to always explore the woman's wants and thoughts as part of the process. I can't help but wonder if every midwife was to practise with these principles at the front of her care, how dramatic the increase in normal and empowering births would be. I have a feeling that approach would do more to reduce the intervention and caesarean rate than any other measure we know about, and it is so simple, it costs nothing and it is a tool available to every midwife should she choose to use it.

The rest of the book is equally good, with chapters covering supporting women with increased risk, cultural expectations, loss, disadvantage, and all focussing on increasing the quality of the relationship between mother and midwife and all giving the midwife tools to help her build that relationship and work with the women they are caring for.

I would recommend this book to every birth supporter and every woman, and I think it is an essential text for midwives. I'm sure even the best will find something to learn, something to use, or a way of fostering good midwifery amongst their colleagues.

Vicki Williams
mum, campaigner and doula

Midwyf Liza

by Valerie Levy
Createspace (17 Aug 2010)
ISBN-10: 1451581211
ISBN-13: 978-1451581218

If you want to escape the stresses of twenty-first century maternity services and enjoy a good historical novel, I recommend this one. Set in the fourteenth century, the plot centres on the life of a village midwife widowed by the plague. It is a life full of dilemmas and hardships. There is intrigue, violence, sex and pestilence in a fast moving plot.

The details of medieval life are fascinating and the midwifery details are correct, as we would expect from a well known midwife. This is a thoroughly good read and would make an excellent present for anyone interested in midwifery, medieval life or a good story.

This is the first of what promises to be a fascinating series of historical novels, each with a midwife as the central character. The book is self published and very inexpensive, it can be ordered from Amazon. I expect that a major publishing house will pick it up soon, at which point the price will double.

Mavis Kirkham

Controlling birth

I watched the ITV show 'The Zoo' last night and was disgusted at the treatment of the elephant who was due to birth. The one thing that hit me full force was the way the animals' births are controlled just as ours are. The staff are then surprised when the animals kill their own babies or hide them, and are confused as to why the animals might do this when these 'lovely' staff are here to 'help'!

The poor elephant had a front and back leg tethered and was not able to move freely as she would have in the wild, nor as freely as she clearly wanted to. Then when her poor baby hit the concrete she couldn't get to him. I thought Vets were supposed to understand mammalian birth, seems I am wrong. I suppose at least they tried to keep everything quiet and dim for her until after she birthed. I also was disgusted that she was not 'allowed' to be with the rest of the elephants, like they would be in the wild.

It's all too common in our labours too: inactive labour, dictated delivery position and then no opportunity to quietly bond with the baby!

I didn't just have issues with the elephant either, I had issues with the dragons and the searching they did for the eggs.

Last week they had a rare bird lay an egg and the parents killed the chick as it was hatching. It was the second time this had happened and the staff were on a 24 hr watch to try and 'save' this new chick. The message is very clear, the parents keep killing the chick because they don't feel it's a safe place to have a chick.

I know the zoo people are trying to save rare breeds but they need to look at the bigger picture!

Kate McCarthy Harris

Where is the support for normal?

I have been privileged to support families whilst they birthed. I have witnessed excellent midwifery which honoured the mother's right to make informed choices regarding her care, place of birth and mode of birth, even when it was against protocol. I have watched very beautiful, physiological births, some of which were calm and some of which were extremely intense. Nearly all the births have had some perceived medical risk, but the overriding impression was that the parents felt empowered, respected and supported in making their own choices.

At the other end of the country the Albany Midwifery Practice in Peckham, South London provided what was regarded by many to be the Gold standard of care, in that they cared for a caseload of local women regardless of their perceived medical or social risk, with excellent outcomes. The Albany gave genuine choice to the women whom it served about place of birth and provided continuity of carer throughout pregnancy, birth and the postnatal period.

Sadly, I know that this is not the norm in the UK. Across the country it can be seen, from women telling their birth stories, that families choosing to birth in obstetric units or who do not know that they are 'allowed' to refuse procedures or to plan home births, for example, are not likely to have such an empowering experience. But why not?

Firstly, the word 'choosing' is somewhat misleading. Speaking to women, it becomes clear that many are not presented with options and therefore cannot make informed decisions. They feel that they have no control over what happens to them, they simply have to do as they are told. But people do have the right to make their own decisions regarding their healthcare. The Nursing and Midwifery Council is very clear on this point, stating: *'Make the care of people your first concern, treating them as individuals and respecting their dignity.'* Unfortunately, many families state that they did not find this in their care. It appears that many midwives are either unable to practise autonomously, finding themselves restricted by Trust policies which do not serve the individual's best interests, or they simply choose not to.

Secondly, there are not enough midwives to provide quality care. Women do not see the same midwife twice in pregnancy and many find themselves sharing a midwife in labour. Royal College of Midwives' General Secretary, Cathy Warwick discussed findings of a survey. *'We are seeing static or falling budgets, yet midwives and maternity services are faced with a continually rising demand,'* she said. *'Whichever way you look at them, the figures are not adding up.'*[1]

Now it appears that the previous Government's commitment to increase midwife numbers by 3,000 in England and Wales will no longer be honoured because the Tories say the increase is no longer needed as the birth rate is stable. Well, there may not currently be an increasing birth rate in England and Wales but midwives are still dealing with falling budgets, more complex births and not enough midwives to cope with demand. This will lead to midwives burning out, resulting in a physical and mental health risk to them as well as to the women and babies in their care.

However, students are qualifying from their midwifery training in some areas to find that they cannot get a full-time position. How can this be?

Thirdly, I feel insulted on behalf of the many fabulous midwives whom I admire and respect, every single time I hear disparaging comments about home births, for example. Do we really not trust our midwives to have been trained sufficiently to care for their women and be able to recognise and deal competently with situations which arise? No wonder midwives are beginning to leave midwifery if they are frustrated at not being able to practise autonomously!

Finally, all this leads me to fear for the women and their babies in the future. Lack of midwives or lack of services will inevitably lead to poorer outcomes. What can be more important than the lives of our childbearing women and their families? Why are we putting the physical and mental health, and lives of our mothers at risk? Unfortunately, when things do go wrong it will be the midwife that takes the blame (as has been seen in recent years by midwives investigated by the NMC using panel members who have no experience or knowledge of midwifery!) and the family will live with the outcome, but those in charge of funding and resources will continue to put their priorities elsewhere.

Karen Law

1. www.bbc.co.uk/news/health-11759702

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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Birthing Autonomy: Women's Experiences of Planning Home Births by Nadine Pilley Edwards, AIMS Vice Chair: Is home birth dangerous for women and babies? Shouldn't women decide where to have their babies? This book brings some balance to difficult arguments about home birth by focusing on women's views and their experiences of planning them. Invaluable for expectant mothers and professionals alike See AIMS website www.aims.org.uk

Birthing Your Baby: The Second Stage by Nadine Edwards and Beverley Beech: Physiology of second stage of labour; advantages of a more relaxed approach to birth £5.00

Breech Birth – What are my options? by Jane Evans: One of the most experienced midwives in Breech Birth offers advice and information for women deciding upon their options £8.00

Choosing a Waterbirth by Beverley Beech: How to arrange a water birth, pool rental, hospitals with pools; help to overcome any obstacles encountered £5.00

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