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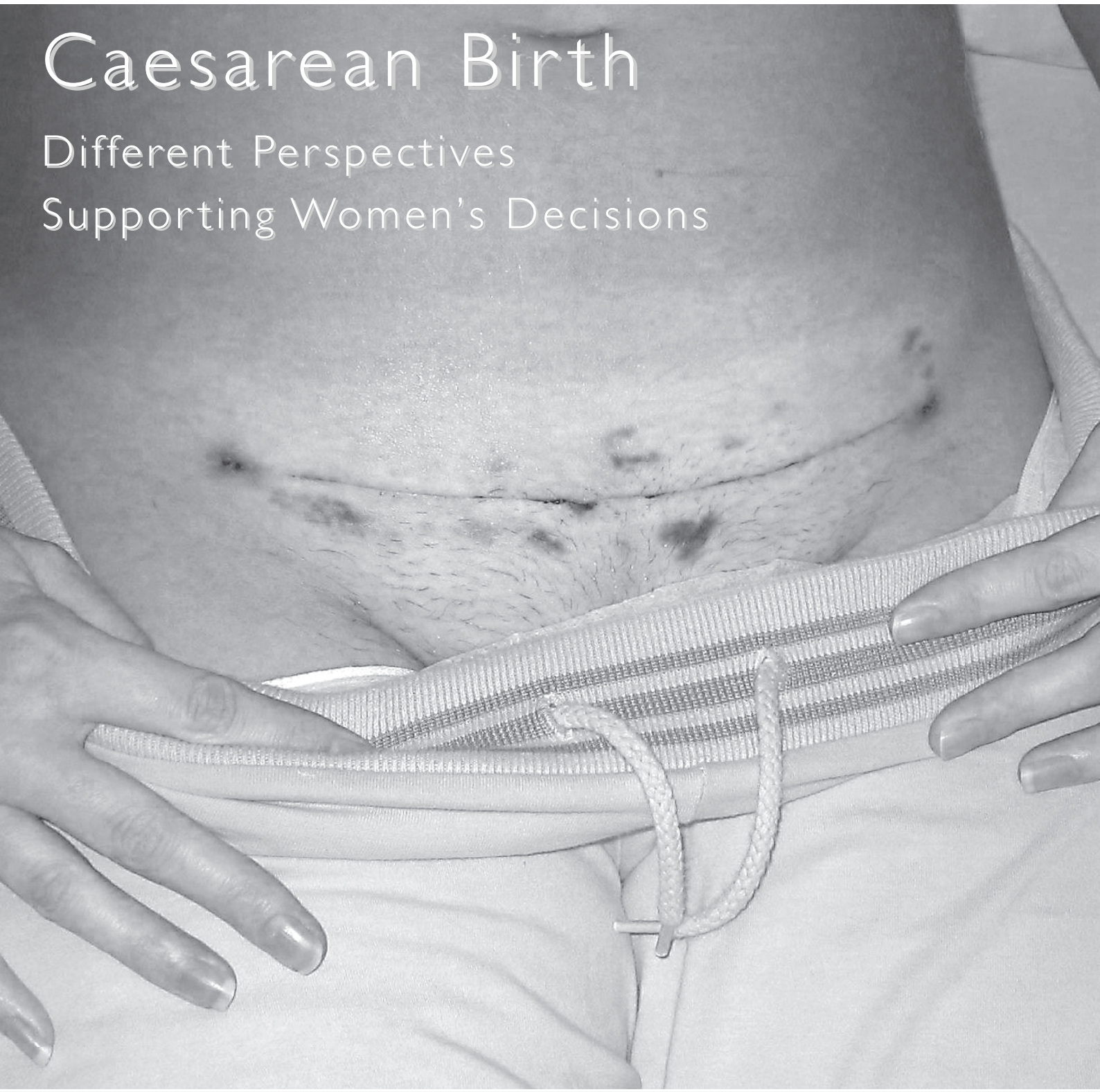
Caesarean Birth

Different Perspectives
Supporting Women's Decisions



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Cover Picture:
Jane-Marie Bates four days after a first caesarean
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Founded by Sally Willington 1931 - 2008

The Rising Tide

Debbie Chippington Derrick and Vicki Williams introduce some of the common themes and issues in supporting women and improving service

Caesareans have, over the last few decades, become an established way of having a baby, yet we still find women struggling with decisions around this birthing method. A caesarean can be lifesaving for a mother and baby and it can be a positive birth experience. However, many women find themselves undergoing this surgery when they are sure it could have been avoided, whilst a few women who needed one during labour still fail to get one quickly enough. Women who feel a planned caesarean is in their best interest can find themselves fighting to find someone to support their decision whilst women who have already had one or more caesarean, a breech baby, twins or some other medical indication for a caesarean continue to struggle to find support for a planned vaginal birth.

Women all feel very differently about their caesarean experiences, and so will all need different approaches when it comes to providing them with support. As with the rest of the maternity system, one size most certainly does not fit all. Many women come away from their birth experiences feeling traumatised, but a frequent theme on the AIMS helpline is not that events which led to a caesarean were clinically difficult and that the surgery was a life-saving emergency, rather it is that women have felt that their needs and opinions were not listened to and that the care they were requesting was unavailable, withheld or simply too late. This emotional damage seems to happen regardless of the eventual method of birth, it is by no means confined to the technically difficult births, nor the surgical ones, nor the ones with lasting physical consequences.

There is a need to listen to women, to respect their needs and autonomy, and to accept that decisions about what is in the best interest of a mother and baby needs to be individualised. Different women with the same medical history will make different decisions about what is right for them, their baby, their family and their life. It is not surprising that this is an issue around caesarean birth, as it is no different to the struggle all women are having with maternity services regardless of how their baby is born.

However, what has been concerning us for some time is that women often seem to be lead to believe that those wanting a natural vaginal birth are trying somehow to prevent other women from making the decision to have a caesarean, and even the perception that those wanting a physiological birth feel superior to those wanting a caesarean, pain relief for labour or other interventions.

Gina Lowdon (on page 4) considers how we got to this state of affairs as caesareans moved from being a rare event used only in the most dire situation to a common way for a baby to be born. She considers how maternity services have evolved since the birth of the NHS, and the needs and actions of the campaigning groups who evolved to try to address the shortfall in the service. She goes on to explain how all women campaigning around birth issues are really campaigning for the same things, and that we all need to support the right of women to have their decisions respected and valued.

On page 12 Debbie Chippington Derrick goes on to consider the needs and issues for women who decide that they want their baby to be born by caesarean; what Gina and Debbie have found they need, how they are currently supported and how they could be supported.

all women campaigning around birth issues are really campaigning for the same

Payment by Results is not allowing Trusts to address how unnecessary and unwanted caesarean could be avoided, because of the significantly large payments made when women undergo caesareans and have complications. This issue is covered on page 16 and looks at the different payments made by complication. It was only very recently that home birth was even covered in this payment schedule, and some activity, notably home visits, parent education classes and breastfeeding support, continue to be excluded from the Payment by Results Tariff and remain within the midwifery block contract. This is subject to local negotiation and is often seen as underfunded or even absent from the care offered.

On page 14 Michelle Barnes reports on her work to address the increasing caesarean rate in Sheffield. Although Michelle has felt that improvements have not been great, it is worth remembering that this work has held the rates static in a climate of rising caesarean rates and the benefits of a non-rise cannot be under-played. Michelle also looks critically at the difficulties of implementing a toolkit which was launched by the NHS, along with the successes that these efforts achieved.

In this issue's birth reports we hear two women's very different experiences of caesarean birth. Natalia Huxley shares her last-minute decision to have a repeat caesarean despite her plan to have a home birth after caesarean, and how positively she feels about the birth. This is contrasted by Deborah Lickfett's experience, where what should have been a straightforward birth degenerated to into a cascade of intervention leading to an avoidable and unwanted caesarean.

Debbie Chippington Derrick and Vicki Williams

All on the same side?

www.caesarean.org.uk co-founder *Gina Lowdon* explores the concept of choosing a caesarean

Sadly, women are often portrayed in the media as being on opposing sides: on the one side are the 'natural' childbirth 'earth mothers' lobbying for women's right to birth at home or in a birth pool, for intervention-free birth in hospital, and for support for breastfeeding; and on the other side are those reported as being 'too posh to push', who want caesareans and epidurals on demand, and who see vaginal birth in any setting as an horrendously frightening, painful and degrading experience, and definitely one to be avoided.

At best these two groups are seen as being on opposite sides of the same coin, at worst they are seen as being mutually exclusive and as having demands and ideas that are in direct opposition. However, they have much in common and are not nearly so far apart as to render impossible shared campaigning objectives.

To state the obvious, all women would like to go through a straightforward, positive experience of bringing a healthy baby into the world. Where women differ is in their beliefs about how best to achieve such an experience; those advocating home birth are at the opposite end of the birthing spectrum to those preferring an elective caesarean. What few seem to realise is that both ends of this continuum share the same underlying principles, and it should be possible to join forces and speak with one voice representing and supporting the needs of both groups (and, indeed, all those in between).

To understand how and why the perceived opposition has come about we have to step back in history. Have the aspirations of women changed and are campaigning objectives still in line with what women really want?

Throughout the ages, right up until relatively recently, birth was a normal life event; women became pregnant, in due course they went into labour, gave birth and continued with their lives. There were no intellectual 'choices' to be made, no complex options to be weighed up; it was simply a case of following life's natural flow of events. Women just had to hope and pray that all would be well.

For most women the birth proceeded normally without major complications and although women could give birth unaided, many preferred to have the companionship and help of other women and/or a midwife.

There is evidence that providing women were able to eat well throughout their lives and pregnancy, maintain good health throughout, and providing their living conditions were of a reasonable quality, then around 95% could expect labour not to present any major hazard.[1234] This figure may seem high, but it must be remembered that throughout history for the remaining 5% or so, complications were such that death was a real possibility. There were also communities who did not have enough to eat or whose living conditions were deplorable and therefore in those communities pregnant women were at much higher risk of general poor health, mal-formed pelves, and consequent higher rates of complications of pregnancy, labour and birth.

Birth was something to look forward to, but it was also something to fear.

From Birth at Home to Hospital Delivery

Before the birth of the NHS in 1948 it was usual practice in the UK for babies to be born at home and midwives were employed either privately or by local council authorities as providers of community services; midwifery care was seen as a community service rather than a health service. The move away from domiciliary delivery (as home birth was termed) to hospital delivery which was already well under way at that time, accelerated with the advent of the NHS; midwifery provision moved from local councils to the health service provider (the NHS), and the emphasis changed as birth became acknowledged as a health issue rather than a normal life event.

Also, and this was crucial for the way birthing practices developed, birth came under the control of doctors and male dominated obstetrics. Doctors had been taking an interest in childbirth for some decades but the move from home to hospital brought the birthing process into the realm of male doctors and medical science, and away from women and midwives and their more socially caring approach. This change was gradual and insidious, but it has been inexorable and has resulted in a complete change in the way birth is approached, seen and understood by our society.

By 1958 the percentage of births still taking place at home had reduced to 36%, by 1970 the rate was down to 13% and by the early 1980s was down as low as around 1%.[5] The driving forces behind the declining home birth rate are complex, but contrary to popular belief there is no evidence that the move contributed to improved health outcomes for mothers or babies. In fact there are strong arguments to support the relative safety of home birth.[6]

By contrast, at the opposite end of the childbirth spectrum rates of caesarean section were increasing. In the first decade of the twentieth century only 74 of 15,222 deliveries were by caesarean section.[7] In these early days of caesarean section a woman was lucky to survive at all, so it was a measure of last resort. By the 1940s numbers of caesarean deliveries were increasing as improved surgical techniques, blood transfusions, anaesthetics, and the introduction of antibiotics reduced the risk of maternal mortality, making the operation more acceptable to the medical profession.

By 1958 2.7% of births were by caesarean section, but with increasing confidence and much improved survival

rates the caesarean rate had doubled to 5.3% of births by 1972.[5] This was still at a level that reflected the number of life-threatening problems that might be encountered in a generally healthy population.[1234] However rates of caesarean delivery across the western world continued to rise. By 1985 the caesarean section rate in the UK had doubled again to 10.5%, and by 2001 there was a further doubling to 21.5%.[8] The latest figures (2007) indicate that the rate may have stabilised at just over 24%.[9] However, if the pattern here in the UK follows that of the USA, this plateau will be short lived and followed by a continued rise.

So how did women feel about the changes reflected in the statistics?

1960s: The Rise of the Interventions

The move from home to hospital as the prominent place for most births was well under way by the 1960s, and with it came a shift in perception. The birthing process and experience ceased to be seen as a normal life event of personal, social and community importance; instead it was viewed as a medical condition and a time of great risk. There was also a shift away from predominantly pastoral care by women (midwives, family and friends) to medical care and conditions of labour that were controlled by men of science (doctors, obstetricians and paediatricians).

Although caesarean rates were increasing they were still low, reaching just 5% by 1970. At that time therefore they did not present a cause for concern for the majority of women, reflecting as they did the level of complications generally encountered. Despite greatly improved outcomes and much lower death rates caesareans were still only carried out when absolutely necessary. Childbirth had never been without its risks and complications and the roughly 5% rate reflected public experience and expectations of trouble. At that time there was no suggestion therefore that caesareans were done inappropriately.

The move to hospital-based, doctor-led care however gave rise to a whole host of medical interventions which affected much larger numbers of women and which therefore did present a whole raft of concerns. Particularly unpopular amongst the early interventions (with both mothers and midwives), were shaving of the pubic hair and enemas to purge the back passage; practices which were believed to reduce infection rates, but which were shown to be ineffective at best[10 11] and which gradually fell into disuse following assertive campaigning by childbirth organisations.

Many women did not like the way they were treated in hospital; there was a lack of privacy, a lack of respect and there were degrading and unpleasant procedures that had to be endured in order to access the perceived greater safety of having medical expertise on hand, and babies were often separated from mothers and placed in nurseries. No-one at that time questioned the validity of the presumption that hospital birth was safer; it was simply accepted as fact.

The Birth of Childbirth Organisations

The strength of feeling against the prevailing conditions was demonstrated by the formation, in the late 1950s/early 1960s of various user groups including: the Natural Childbirth Trust (1956) which became The National Childbirth Trust (NCT); The Society for the Prevention of Cruelty to Pregnant Women (1959) which became the Association for Improvements in the Maternity Services (AIMS) in 1960 and the National Association for the Welfare of Children in Hospital (NAWCH 1963) which became Action for Sick Children.

The NCT focused on educating women to increase their confidence in the natural birth process and enable them to be more self-sufficient so they would not feel the need to avail themselves of hospital care. Their philosophy was based on the teachings of Grantly Dick-Read who had demonstrated that by understanding and working with the natural birth process complications could be kept below around 5% in healthy women.[1]

AIMS was more concerned with the way women were treated in hospital, which Sally Willington, founder of AIMS, considered amounted to cruelty to women, hence the initial nomenclature of AIMS. The general perception that hospital birth was safer was not in contention at that time and one of AIMS' early campaigns was for more hospital beds so that women who needed, or wanted, to give birth in hospital could do so.

a range of interventions which became common place

Throughout the 1960s experience of birth in hospital left much to be desired. Rates of caesarean section were increasing but they were still low enough not to present an issue for the majority of women. The medicalisation of birth that came with the move to hospitals however brought a range of interventions which became common place and, with the possible exception of pain relief, universally disliked, such as pubic shaving, enemas, induction, augmentation, episiotomy. Campaigning by user groups focused on trying to persuade the maternity services to treat women and their babies more humanely.

The interventions themselves were accepted as necessary to preserve health and life and the concern, as it has been earlier with the number of hospital places, was the shortfall in service provision – all women who would benefit should have access to modern medical care, particularly pain relief.

1970s: The Demise of Home Birth

By the early 1970s it became clear that the option of home birth was being phased out. As fewer women gave birth at home more women were subjected to hospital protocols. Many who would have laboured perfectly well in the familiar environment of their own home attended

by a known midwife found hospital labour wards impersonal, unpleasant and unsettling, with the result that their labours stalled or slowed down and became subjected to the growing range of interventions, including caesarean section. Not surprisingly, intervention rates of all kinds rose as the birth process became increasingly medicalised and mechanised, and rates of caesarean section soon followed suit.

For a large proportion of women this was incomprehensible. Although many women had been led to believe hospital was safer for them and their babies, many others could not understand what the fuss was about; the vast majority of women had managed just fine since time began. Hospital delivery was proving to be inconvenient, unpleasant and degrading and did not seem to have much to offer women who maintained confidence in the natural birth process and had no reason to expect difficulties, particularly if they were fortunate enough to live in an area covered by a known and trusted midwife or had the option of a good local GP unit.

inconvenient, unpleasant and degrading and did not seem to have much to offer women

There was alarm at the phasing out of home birth as an option for women, and Margaret Whyte took a lead by raising awareness of this situation in 1972 when she set up the Society to Support Home Confinements. Following her lead AIMS too became interested in the issue and began campaigning for the right of women to have a home birth. Whilst those women who needed or wanted to give birth in hospital should be able to do so, so too should women be able to give birth at home as they always had done through the ages. Despite all efforts and the great many women who still preferred to give birth at home, home birth rates continued to fall, dropping to less than 1% by the early 1980s.

Such initiatives were backed by substantial numbers of women; those who felt strongly enough to 'create a fuss' and make their views known. At that time there were no groups of women arguing against natural birth, at home or in hospital: that argument was being raised solely by the medical profession.

During the 1970s the dangers of home birth as perceived by many in the medical profession and increasing numbers of the general population began to be called into question. Although the Peel Report of 1970[12] had implied that hospital birth was safer, it was criticised for the lack of evidence to support the implication. Archie Cochrane was one of the first critics in 1972 in his book 'Effectiveness and Efficiency'[13] and much later, in 1990, Marjorie Tew gave a detailed assessment of the statistical evidence in her book 'Safer Childbirth'[6] indicating the relative safety of home birth. Unfortunately, despite consistent and clear evidence to the contrary, home birth continues to be viewed by the majority as inadvisable at best and highly risky at worst.

Throughout the 1970s and 1980s awareness grew among childbirth organisations that the option of safe and peaceful birth at home had been all but lost, stolen away by false promises and misconceptions concerning safety. Campaigning objectives focused on trying to recover the more gentle approach to birth that had served women so well for millennia. Hospital birth with its potentially life-saving medical technology was acknowledged as being necessary for those who were in need, but awareness was growing amongst campaigners that inappropriate use of the growing range of interventions could bring harm as well as benefit.

Not all women were aware of the bigger picture but a significant number were. Those who felt traumatised by their experiences, who searched for information, who questioned the appropriateness of their care, found out that medical science was often far too enthusiastic and impatient, leading to injudicious use of interventions. But these women were far outnumbered by those who remained uninformed and who were left with the belief that unpleasant though hospital birth was, it was necessary for safe birth.

1980s: Caesarean birth becomes established

As rates of home birth hit their lowest levels by the early 1980s (around 1%), rates of caesarean section were becoming a concern. A decade earlier, 1970 had seen the USA and the UK with similar caesarean section rates of around 5%.[5] By 1978 the rate in the USA had tripled to 15.2% and women were starting to question the need for so many operations and began to fight back. The American organisation C/SEC Inc was founded in 1973 by women who suspected their caesareans had not been necessary and by 1981 one of C/SEC's founders, Nancy Wainer Cohen, was hard at work on 'Silent Knife: Caesarean Prevention and Vaginal Birth After Caesarean'.[14]

Silent Knife was published in 1983 and questioned every aspect of caesarean birth, including the inherent risks of this surgery to both mother and baby, the psychological affects on mothers of operations carried out for dubious indications, and the strength of the resultant scar which was shown to be considerably less prone to rupture than women had been led to believe. Silent Knife was an important book that gave women research-based facts and marked the beginning of the VBAC (vaginal birth after caesarean) movement in the USA.

Caesarean rates were slower to rise in the UK and, unlike in the USA, VBAC had always been accepted practice, but childbirth organisations were being contacted by increasing numbers of women who were unhappy and even traumatised, not just by their experiences on labour wards, but also by the resulting caesarean sections, and who were suffering a range of long term physical and medical consequences as well as trauma.

Not all women were unhappy with their caesarean births. Many were grateful that such a life preserving and relatively safe procedure was available. Although an unfortunate few found themselves facing short- and long-term difficulties as a result of their surgery, most caesarean mothers and their babies came through without encountering significant problems.

But, as the rate of caesareans increased, so did both the need for information and awareness that caesarean birth was not always problem-free. Whether women were at peace with their caesarean experience or not, many sought answers to a variety of questions. Unfortunately, a great many were not able to find the support and information they needed.

Established childbirth organisations had been focused on healthy women and the unpleasantness of interventions imposed on women on labour wards. It was widely believed that caesareans were only carried out when necessary and beneficial and were therefore strictly the domain of the medical experts. Lay organisations considered it neither appropriate nor wise to appear to be giving out information that might remotely be considered as 'medical advice' and thus considered caesarean issues as being outside their remit. Even childbirth preparation classes were criticised for not covering caesarean sections which were viewed solely as a medical emergency (rather than a birth).

Just as in the 1950s, 1960s and 1970s women expressed their views and attitudes by forming groups, sharing and disseminating information and experiences. Due to the lack of support from the established childbirth organisations, from 1981 onwards caesarean mothers began getting together to form self-help groups which Sheila Tunstall coordinated into the Caesarean Support Network.

widespread lack of understanding of the problems

As the caesarean section rate continued to climb to over 10% in the UK[15] by the end of the 1980s, so too did the numbers of women dissatisfied and even traumatised by their caesarean experiences. The caesarean rate was now twice the general level of complications that people had been used to, but the prevailing view that every caesarean was carried out because there was a good cause meant there was widespread lack of understanding of the problems, and puzzlement over how any woman could view a procedure that must have saved her baby so negatively; it was simply not politically correct or acceptable to express negative feelings relating to caesarean operations and these women struggled to find support.

This period marked the start of the divide between those women who either gratefully accepted the necessity for their caesarean births and/or viewed them as an escape route from a bad vaginal birth experience, and those on the other side of the coin who suspected surgery had been resorted to inappropriately. By the end of the 1980s the operation was sufficiently commonplace that general information was more widely available as women shared their experiences and knowledge, but negative emotional responses were still frowned upon and largely misunderstood.

By 1990 caesarean birth was well established with rates of around 11%[15] whilst home birth rates remained negligible at around 1-2%.[16] For the vast majority of women home birth was simply no longer an option to be considered seriously, it was no longer a part of the lived experience of the general population or part of current culture. Birth was no longer accepted as a natural life process; it was now firmly established as a fully medicalised event suited only to a hospital setting.

1990s: Evidence-Based Practice – a new campaigning tool

The 1990s was the decade where user groups turned to research evidence to support their campaigning objectives. Women had never been healthier, nor living conditions better, but as rates of interventions of all kinds, including caesarean sections, continued to rise alarmingly it became abundantly clear that substantial numbers of women were suffering the consequences. Birth had become a matter for medical science (irrespective of how healthy the woman was) and childbirth organisations could no longer confine their activities to the ever dwindling proportion of women considered 'normal' and 'healthy'; the 'medical domain' nettle had to be firmly grasped.

During the 1990s medical research and scientific evidence became more widely accessible and provided invaluable support for many of the arguments childbirth campaigners had been putting forward for decades as well as a firm basis on which to challenge medical opinion. Evidence showed that interventions of all kinds were not only unpleasant and often used unnecessarily but that they also had significant adverse effects.

Research evidence supported both the instincts and the lived experience of many caesarean mothers, demonstrating little improvement in outcome statistics when caesarean rates rose above 7% and recording evidence of associated risks for both mothers and babies.[11] (However, the full spectrum of adverse affects for an individual baby of not being born vaginally may still not be fully understood as more recent research findings indicate.)[17 18 19]

The general public however remained largely unaware of such risks and continued to believe that interventions were always beneficial and that every caesarean must be a much needed life-saver. A significant proportion of women too, were left believing that events on the labour ward and in the operating theatre had been unavoidable and that without the aid of medical science their babies may not have been born safely.

The VBAC movement comes to the UK

By the mid-1990s the caesarean section rate reached 15%[20] in the UK - the same level reached in the USA some two decades earlier that had prompted the formation of C/SEC and the publication of Silent Knife. It seems a 15% caesarean section rate marks the point where levels of discontent result in women fighting back - the VBAC movement became firmly established in the UK.

Childbirth organisations continued to receive the steady flow of enquiries from caesarean mothers expressing a need for information and support that had begun in the early 1980s, but with the move towards research-based campaigning the barriers presented by the perceived medical nature of caesareans were overcome and women started to find their concerns being taken on board.

Consequently, understanding of women's negative reactions to caesarean surgery grew and became accepted by the established childbirth organisations as realisation dawned that those preferring to avoid surgery and the 'cascade of interventions' that all to often led to the operating theatre, were fighting the same battles as those preferring birth at home or intervention-free birth in hospital; albeit with the added complication of a scarred uterus.

The division of caesarean mothers into those at peace with their caesarean births and those dissatisfied and even traumatised by their experiences that had begun to be apparent in the 1980s became more pronounced as the VBAC movement gained pace.

VBAC activists were uncovering research-based information that questioned the need for so many caesarean operations and challenged the basis of decisions taken by medical experts. Many mothers who were at peace with their caesareans felt threatened by this new information since the only way many were able to cope with all they had been through was by continuing in the belief that it had all been necessary (and thus justified) for the health of their baby.

The 1990s saw VBAC campaigners and childbirth organisations with shared campaigning objectives highlighting inappropriate care, poor access to information and inadequacies in service provision that rendered women powerless victims of an unnecessarily medicalised system. However their approach was widely misunderstood by the general population and many caesarean mothers whose faith in medical expertise and continued belief in the dangers inherent in the birth process remained unshaken.

Clinical indications for caesarean section such as 'failure to progress' or 'cephalopelvic disproportion' (small pelvis, big baby) carried the not so subtle implication that interventions and caesareans rates were the result of some failing on the part of childbearing women. The medical profession were certainly not open to the idea that problems were the result of ill-advised forms of care and the vast majority of women were not ready to doubt the advice of their doctors.

Many caesarean mothers were therefore simply not ready to question the basis of their caesarean experience; some saw their caesarean as an escape route from a horrible vaginal birth experience and indeed many others had undergone caesarean sections for wholly appropriate reasons. The natural response of many of these women to the VBAC campaigns was a general perception that they were being blamed for bringing their experiences on themselves due to some personal inadequacy or failing; they felt under personal attack.

some saw their caesarean as an escape route

VBAC campaigners where branded as 'anti-caesarean' and childbirth organisations were frequently accused of failing to fully support all caesarean mothers, and of only valuing those women who were able to give birth 'properly' in some masochistic, competitive, Amazonian way; those who didn't were left with the distinct impression they were not 'real' women.

The Advent of Maternal Request for Caesarean Section

Caesarean mothers who felt negatively about their childbirth experience broadly fell into two groups: on the one hand were those who valued the natural birth process, who doubted the supposed benefits of their caesarean section and who were highly motivated to avoid repeat surgery in future, and on the other were those with no confidence in the natural birth process who considered their caesarean a welcome relief from a harrowing labour and who were therefore determined to avoid a similar experience in any future pregnancies by undergoing elective (planned in advance) caesarean births.

As the 1990s came to a close with caesarean rates in the region of 20% and rising, the widespread debate that had been taking place throughout the western world reached a general consensus that caesarean section rates were too high and should be reduced. Consequently the maternity services came under pressure from childbirth organisations, health service providers and government bodies to reduce the number of caesarean operations taking place. Some obstetricians became reluctant to agree to caesareans in the absence of a clear clinical indication and women expressing a strong preference for caesarean birth began to encounter a lack of sympathy for their needs and refusal of their requests. For those who simply could not face the prospect of a vaginal birth or who perceived it as being detrimental for their baby, the denial of their only other birth option was alarming.

Established childbirth organisations began receiving increasing numbers of enquiries from women distraught at being forced to labour against their will as their escape route was closed off. The majority had already been through a traumatic experience and found the thought of repeating it terrifying; others had heard many horror stories from friends and relatives and dreaded a similar experience. Unfortunately however, whereas it had once

been unacceptable to express negative feelings regarding caesarean birth, the pendulum had swung and by the end of the 1990s it was no longer acceptable to express a preference for caesarean birth. Yet again, a significant group of women were finding support and understanding difficult to find.

Media coverage of the issues was particularly unhelpful with confusion over the term 'elective caesarean' which was interpreted by many journalists to mean the caesarean was 'chosen by' or 'opted for' by the women themselves, often implying there was no underlying clinical indication. (The term 'elective caesarean' simply means 'planned in advance' as opposed to 'emergency caesarean' which in its original sense means that the indication 'emerged', that is, it was 'unforeseen' or 'unplanned'.)

The phrase 'too posh to push' coined shortly after the birth of Victoria Beckham's son in 1999 added insult to injury implying as it does that women requesting caesareans were not prepared to demean themselves by going though labour.

It was also an inaccurate analogy since by all accounts Victoria did have a clinical indication for caesarean section – her son was a breech presentation and she would have been strongly advised by her private obstetric-led care to have a caesarean. With her second pregnancy it is very unlikely that a VBAC would have been encouraged in the private obstetric sector. A more accurate phrase would have been 'conned and cut' since new evidence shows that breech babies can safely be born vaginally and that VBAC generally carries lower risk than planned repeat caesarean, but Victoria was doubtless misled as are so many women in similar situations.

Caesarean mothers on both sides of the divide deplored the media misunderstanding. Those at peace with their caesareans had not undergone their operations for frivolous reasons of fancy but for clear medical indications on the advice of their obstetricians and for the well-being of their babies. Those unhappy at having undergone surgery were indignant at being portrayed as having supposedly chosen a procedure they had definitely not wanted, had been given no choice over and the necessity of which they had come to doubt.

There was widespread misunderstanding of both the extent and the driving forces behind maternal request for caesarean section and a consequent lack of respect and consideration for the perspectives of those women who were genuinely expressing a preference for caesarean birth.

The New Millennium: Birth as a Medical Process

By the dawn of the New Millennium, birth as experienced by women in all western cultures had been transformed. The collective consciousness was generally unaware of the inherent benefits to both mother and baby of a truly natural birth process; those had become secrets known only to a dwindling number of mothers and grandmothers. With the passing of the decades the memory of straightforward, gentle, safe and caring birth at home was fading; confidence in the ability of women to give birth remained at an all time low. Intervention-free birth or birth at home was no longer an option for consideration by the majority of women - they simply didn't know it existed.

What the collective consciousness was only too well aware of were the difficulties experienced by women on our labour wards. Birth was no longer a normal life event but a medical condition requiring monitoring and intervention prescribed by doctors in hospitals. Women had been taught to fear birth, to believe that interventions were necessary to safeguard their babies. Indeed fear of birth had become endemic in western cultures; birth outside hospital, away from potentially life-saving medical intervention was almost universally considered to be dangerous and irresponsible despite evidence to the contrary. Hospital labour wards had a virtual monopoly and control over public perception of the birth process.

Monopolies are rarely conducive of diversity and provision of good service. The medicalisation of birth requires that women are processed through a system focused on checking, measuring and managing - all highly scientific and clinical, and all carried out in the name of safety. Scant, if any, consideration is given to the way the 'system' impacts on women psychologically.

ensure the woman's labour did not deviate from ever narrowing criteria considered to represent 'normal'

The role of midwives had also changed. Most midwives had become obstetric nurses, trained to carry out checks and make notes, and to ensure the woman's labour did not deviate from ever narrowing criteria considered to represent 'normal'. The emphasis was now on detecting abnormality rather than safe-guarding normality. Disenfranchised midwives had been leaving the profession in droves for decades and the resultant shortages of experienced midwifery staff further exacerbated the inadequate care received by labouring women as hard pressed midwives endeavoured to oversee several women simultaneously, rendering impossible the sort of individualised care that used to be central to the midwife's role.

Whilst labour wards claimed to offer increased safety, they did so at the expense of individualised care. Had one-to-one midwifery care by a known midwife followed women from the home into hospital things might have been different, but hospitals were the domain of doctors and disease, not midwives and normal life processes. Hospitals are about rotas and shifts, measuring and monitoring, statistics and clinical indications, none of which allow for the timings and individuality of the rich variety of normal, natural healthy labour.

By the New Millennium caesarean rates were approaching or exceeding 20%.[20] Medical advances had greatly reduced surgical risks and complications making caesarean birth a viable alternative. Short and long term consequences were relatively uncommon, poorly understood, and generally unnoticed by all but those women unfortunate enough to suffer from them. Caesarean birth now offered women an alternative to the labour ward experience of vaginal birth - and increasing numbers were considering it the lesser of two evils.

Today: The Divide Deepens

As we reach the end of the first decade of the 21st century caesarean rates appear to have stabilised at just over 24%,[9] although the pessimists among us expect them to rise again as they have done in the USA. Despite the best efforts of lay and midwifery groups and considerable support from various government documents,[20 21 22] home birth rates have only rallied marginally to around 3%,[23] and rates of interventions have reached unprecedented levels. It has been estimated that fewer than 10% of women now experience a birth process free of interventions.[24] Every day, healthy women who have passed a problem-free pregnancy enter hospitals in spontaneous labour and leave some while later having undergone major abdominal surgery, yet this state of affairs is regarded as acceptable and even expected.

An ever dwindling number of women are now having a positive experience of giving birth. The phrase 'normal birth' has become synonymous with a highly managed medicalised labour that nonetheless results in a baby being born vaginally without forceps or ventouse. 'Normal' it may well be in these troubled times, but clearly this idea of 'normal' bears no relation to the normal functioning of a woman's body in labour. Women themselves are also becoming less aware of the difference between 'normal' and 'natural' - it is not unusual for a woman to state she does not want another 'natural' birth when in reality what she has experienced is what passes for 'normal' birth today, which is far from natural and equates merely to the avoidance of a surgical or instrumental birth. Most women no longer know what a truly natural birth can be like.

Quite simply birth on today's labour wards just isn't 'nice'.

In little more than half a century birth has been transformed - and its new form is not very pretty. Birth used to be a normal life event which took place in familiar and comfortable surroundings at a pace that was tailor-made to suit the needs of the individual woman and baby. Birth used to take place in privacy, with only those invited by the woman present. Birth is now a fully medicalised, impersonal event allowing little privacy, which takes place in unfamiliar and uncomfortable surroundings at a pace dictated by medical experts based on statistics. Women have little or no say in who will be present, who will attend them, what is done to them during the process, and indeed in many cases the steady stream of health professionals may remain nameless.

Quite simply birth on today's labour wards just isn't 'nice'.

It isn't nice having someone put their hand in your vagina in order to carry out a vaginal examination. It isn't nice having needles stuck into you for the purposes of injections, canulas and drips. It isn't nice being given drugs to make your uterus work faster. It isn't nice being trapped on your back in a bed when you want to move position to ease your discomfort. It isn't nice having no-one pleasant to talk to because the midwife (if she is actually in the room) is too busy with machines and paperwork. It isn't nice being bored while you lie there waiting for something to happen. It isn't nice being worried, anxious, frightened, because no-one cares that you are feeling superfluous to this whole process. It isn't nice being left with damaged genitals resulting from rushed births, enforced pushing and general ill-advised care. And it is absolutely horrible having someone mutilate your genitals in the name of an episiotomy.

Believing that all this is done in the name of safer birth does not make it any nicer or any less degrading. Let's be absolutely clear here, women only put up with it all because there is a baby to safeguard. Without the expectation of a baby no-one would be prepared to endure such an experience.

It is abundantly clear that all women still want the same things in pregnancy and birth that they have always done - a comfortable pregnancy, a straightforward birth without problems and without pain, and of course most importantly, a healthy baby. Women are prepared to sacrifice a huge amount for their babies, something which is taken unfair advantage of by many health professionals.

Modern medicine has failed in its promises to women and unfortunately, like the proverbial runaway train, the medicalisation of birth shows no signs of slowing down. The approach to care that women find so unpleasant but which so many feel they have no option but to submit to for the welfare of their babies, continues to become more entrenched and intractable.

The gulf has widened between those women who understand the benefits of the natural birth process and those on the other side of the coin who can't even imagine them, for whom 'normal' birth equates to the labour ward definition of 'vaginal' and from which major abdominal surgery has come to offer an attractive route of escape.

All on the Same Side – Building Bridges

Despite the apparent gulf, these two groups of women are not really so far apart; they are all on the same side. Both ends of the spectrum share the common aim of trying to avoid what passes for normal birth on hospital labour wards. In these modern times there are two ways of avoiding a difficult and unpleasant vaginal birth experience: one is to have a good vaginal birth experience and the other is to have a planned caesarean

section. Childbirth organisations and campaigners need to be aware that representing all women now includes those for whom a good experience of vaginal birth is no longer an accessible option and who therefore need the alternative of planned caesarean section.

And that is the crux of the problem - not how a woman sees caesarean birth, but how a woman perceives vaginal birth.

For those who have been campaigning over recent decades the knowledge that vaginal birth can be safe, pleasant and something to treasure and look forward to is unquestionable; it is plain, obvious fact. But for a growing number of women vaginal birth is perceived as unpleasant, frightening, impersonal, degrading, dirty, painful and dangerous. It is an indictment of our maternity services that conditions women endure during labour in western cultures are so dire that women are prepared to undergo major abdominal surgery in order to avoid it.

Campaigns for improvements in maternity care need to take into account the needs of women at both ends of the birthing spectrum.

Campaigning to reduce unacceptably high caesarean section rates should take care to focus on unwanted caesareans and to avoid closing off the much needed escape route for women unable to consider vaginal birth positively. There needs to be much greater awareness and acknowledgement that psychological need ***is*** a clinical indication for caesarean section. Women who are expressing a preference for caesarean birth deserve to have their psychological needs assessed and respected. They are expressing real fears, real concerns. Too often genuine psychological need is brushed aside and dismissed as unfounded, frivolous 'maternal request'.

Campaigning for one-to-one midwifery which has the potential to transform the experience of giving birth for women, should also acknowledge that those women with real medical concerns may appreciate one-to-one care from a specialist doctor as well as a midwife. Time and time again it is evident that those women who have built up personal relationships with their health professionals fare better – whether they are healthy women getting to know their midwife, whether they have a serious medical problem requiring the expertise of a doctor or obstetrician, or whether they are one of the unfortunate few coping with a tragedy.

Campaigning for choice over place of birth should openly acknowledge that women plan home births on the basis of perceived greater safety and a more appropriate model of care, and that women expressing a preference for caesarean section also do so on the basis of perceived greater safety and a more acceptable model of care. Who is right or wrong on the basis of general statistics and medical evidence is not the issue; each woman makes a highly personal decision based on her intimate knowledge of her individual circumstances which are likely to cover a considerably wider spectrum than is taken into account by statistics or medical professionals.

Those at both ends of the birthing spectrum need to take care when campaigning that they are not calling for measures that restrict the options of those at the other end of the continuum. Women rarely, if ever, make frivolous 'choices' when it comes to birth options. Decisions are always based on an intimate knowledge of their own personal situation and needs, even in cases where it might not be immediately apparent.

Whatever the current campaigning objectives, until such time as the birth process is again reclaimed by women as something to look forward to, something unique and special, something perceived as a rare opportunity to be embraced and coveted, until our culture regains the knowledge and understanding of what birth used to be and can be again, then it is likely that women will continue to seek to avoid it in favour of the alternative our technological culture has provided – caesarean section.

Could there be any worse indictment of the care provided by our obstetric-led maternity services?

Gina Lowdon

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Supporting Women

Debbie Chippington Derrick explains more about supporting women requesting a caesarean

Gina Lowdon and I have been supporting women on caesarean and VBAC issues for over 20 years. In the early years most enquiries were by phone and came through NCT, AIMS or the Caesarean Support Network. The majority of enquiries at that time were from women who were struggling to come to terms with their caesarean, wanting to know how to avoid having another one, or trying to plan a good caesarean when they had a medical reason for their baby to be delivered this way.

In the early days we had the occasional enquiry from a woman who felt that she should have a caesarean and was trying to find support for this; however, usually these women had a medical reason that was just not being taken seriously, such as a problem with their back or an illness that caused them excessive fatigue.

As time went on we began to receive more enquiries from women who were wanting a caesarean in order to avoid a vaginal birth, and in 2002 when we set up the website www.caesarean.org.uk the number of these enquiries was increasing. We found we were receiving enquiries via the site from both extremes of the birth spectrum; women with a list of supposed indications fighting for support to avoid surgery and women without any clearly accepted medical indications for a caesarean wanting one in order to avoid labour.

Why do they want a caesarean?

Some women have a simple clear reason for preferring caesarean birth, such as a bad previous birth experience or having been sexually assaulted or raped. Others with a strong fear of the birth process are able to pinpoint events that have led to their fear, such as being admitted to a maternity ward for a gynaecological reason, having a friend lose a baby, being with a sister or friend for their birth and watching them suffer. However, others have deep emotional fear of birth that they can't explain.

Women who have grown up with a terror of birth will see a caesarean as a solution to their problem

Women wanting a caesarean talk about things like the unacceptability and unpredictability of a vaginal birth, a fear of birth, terrible frightening emotions, being terrified, it 'scaring the hell out of them', having a deep-rooted fear, a phobic terror, or being filled with dread. Many tell us these feelings have been with them a long time, or that they have felt like this for as long as they can remember.

Some women have particular concerns such as worrying that they may be too petite to birth a baby, or that they will have a large baby and are often able to quote others in their families who have had problems because of these factors. These are also typical reasons given by the medical profession to explain why labours stall, or forceps or caesareans are needed, and these women have taken on board such explanations despite lack of given evidence supporting these theories. Other women may have had someone close to them lose a baby and consequently view birth as dangerous.

I think it is critically important to understand the way these women view birth. Women who have grown up with a terror of birth will see a caesarean as a solution to their problem. Some women will have been brought up to see a caesarean as their right, such as women brought up Brazil, South Africa, Singapore, and other areas where caesareans are seen as the privileged way to have a baby, and may have never considered that they would do anything else but have a caesarean. Sometimes practical issues can be solved by a caesarean too, such as a partner who is in the armed forces who may only be able to be present at a birth that is scheduled to take place on a specific date. Some women will come from families where they and their siblings were all born by caesarean and they will have grown up with the assumption that their own children would need to be born this way too, for them caesarean birth is accepted normality.

In some cases women take great care to avoid getting pregnant unless they can be reassured that they will be able to have a caesarean; and we are aware of a few women who have terminated a pregnancy because of a fear of birth and because agreement for a caesarean seemed unlikely.

What do we offer them?

For women enquiring about requesting a caesarean our usual starting point is an explanation of their rights, in that they can't demand a caesarean, but can insist on a second opinion allowing them to make their request to someone else if they don't find their initial consultant supportive. If they are not yet pregnant we encourage them to start discussions before they are pregnant, explaining that they may need to be insistent in order to get an appointment. We believe addressing these issues is necessary to put them back in control before we can explore any other aspects with them.

We provide a listening ear (usually on email), giving them a chance to explore their fears and helping them to be able to consider other options, whilst avoiding being judgmental or pushy. We also try to explain some of the childbirth and maternity services issues that may have led

to their perception of birth. This will often include discussing home birth and independent midwifery as issues such as privacy, dignity and control are better addressed by these care options; and these factors are often crucial for these women.

We encourage them to contact a senior midwife as well as to speak to their consultant and we provide them with a range of other sources of information as well as contacts for discussion groups.

We make it clear that this is their decision and that they can be in control of getting what they need for their birth. Finally we make it clear that they can come back to us at any time for further support.

How are they treated by the NHS?

In a few places staff are providing really good support to these women, listening to their needs, helping them access better continuity of midwifery care and psychological support, and making sure throughout their pregnancy and birth that they are supported. Usually women will get the agreement that they want from their consultant, and the suggestion of seeking a second opinion has usually been sufficient when they have met resistance.

The majority of women will find some staff who are understanding, but because care is so fragmented it is usual for them to have to repeatedly explain their situation and their needs. Even when an agreement about a caesarean has been made and documented in their notes, those caring for them will want to start the discussions from scratch with the result that women can become defensive because it can seem the agreement that has been reached may be overturned. Women also often talk about people being nasty to them and say that they feel that this is because they feel accused of making a 'wrong' choice.

It is also not uncommon for crucial information not to be included in women's notes. For example, when women have been referred to a psychologist, information provided by the psychologist supporting the basis of psychological need as a clinical indication for caesarean may be missing from the woman's notes, and even if it is there those caring for her will not have had time to read it.

What do they eventually do?

Most of these women will get a caesarean, but many still do not feel well supported, and they come through birth (as the majority of women do) with a feeling that they have suffered what they have to suffer in order to have a baby, they have survived it and must now move on to parenting their child.

In a few cases women have been so poorly supported that they have terminated a pregnancy, paid for a private caesarean or gone to another country to get one. Others have been forced to labour against their will, only to get an unplanned caesarean due to failure to progress.

At times though, women will be well supported and come through their experience with a new air of confidence; they will have had control returned to them and they come through the birth with that air of being able to cope with anything life throws at them. They, like the mother who has had a really good home birth, feel like screaming their achievement from the top of a mountain.

Occasionally women will be able to find a way to address their fears of vaginal birth. They may get good psychological therapy, and/or excellent midwifery support which enables them to give a vaginal birth a go. Often these women will also have in place an agreement that they can opt out and have a planned caesarean should they feel that they can cope no longer.

if the caesarean had not been agreed there is no way she could have had the wonderful birth

However, the woman who stands out in my mind had negotiated her caesarean and had every intention of going through with it, but went into labour before the booked date. She arrived at the hospital and was reassured that they would get her to theatre soon, by people whom she had met before and trusted to respect and support her. She was relaxed and surprised at how well she was coping with labour, and I am sure that the staff who had dealt with her previously must have been surprised too. She then asked to be allowed to labour a little longer, and before long got an urge to push. There was concern about getting her to theatre rapidly, but she then asked to carry on and quickly gave birth to her daughter herself. She was so proud of what she had done, but remained adamant that if the caesarean had not been agreed there is no way she could have had the wonderful birth that she did.

How could these women be supported better?

If all women where getting one-to-one midwifery care then I feel a lot of the problems would immediately be addressed. However, until that is a reality these women need to be supported within our fragmented services.

These women need to be able to get support from a consultant in order to be reassured that a caesarean can be provided, but they really should be referred to psychological services to see if their issues can be sufficiently addressed to make a vaginal birth an acceptable option for them or to provide a medical diagnosis for the need for a caesarean on psychological grounds. They should also have good midwifery care, preferably from as few midwives as is possible, so that they can be confident that they will be well supported however they birth their baby.

Debbie Chippington Derrick
caesarean.org.uk

Increasing Normality

Michelle Barnes shares her one woman attempt to reduce the Caesarean rate in Sheffield

Caesarean Section (CS) rates have been rising steadily over the last 20 years, with no proven health benefit to mother or baby when the rate exceeds 10%, yet the 2008/9 rate for England stands at 24.6%.[1]

In November 2007 I took over as Chair of Sheffield MSLC (Maternity Services Liaison Committee). I was full of energy and determined to really make a difference. Having experienced an avoidable emergency caesarean, and still dealing with the emotional aftermath, I decided that increasing normality and reducing the CS rate should be top priority for the MSLC, but unfortunately service providers, at the Jessop Wing, weren't quite as enthusiastic.

So at the beginning of 2009 I wrote a letter to the Chief Executive, at Sheffield Teaching Hospital Trust, highlighting my concerns about the rising CS rate, in Sheffield (24.5% in 2008). This letter, titled 'The Power of User Pressure', was published in the AIMS Journal, Vol 21, No 1, Campaigning, Complaining and Caring, Summer 2009.

In my letter to the Chief Executive I recommended the Trust use a Toolkit which was launched by the NHS Institute for Innovation and Improvement called 'Promoting Normal Birth and Reducing Caesarean Sections'. The toolkit is designed to help staff and user representatives work together and think about ways to facilitate normal birth and prevent unnecessary surgery.

The Toolkit was developed by a team comprising an obstetrician and two midwives, who visited units across the country with both high and low CS rates. They concluded that there was a general belief amongst clinicians that maternity units applying best practice to pregnancy, labour and birth, will achieve a CS rate below 20%, with aspirations to reduce this to 15%.

The Head of Midwifery notified me that my letter had caused an initial increase in the number of normal births. Then shortly after this I was invited, as Chair of Sheffield MSLC, to support the Trusts application, to the Department of Health National Support Team, for help in using the Toolkit.

The application was successful and after a series of meetings the Trust decided to focus on the First Pregnancy and Labour Pathway, because it was thought that if you can lower the CS rate with first time mothers there will eventually be a knock on effect.

The Change Process

On the whole the Jessop Wing has reacted really well to the programme of change.

I was involved in looking at the birthing environment and made suggestions for improving it, making it more homely and adding props to make labour more comfortable such as a new birthing chair. The organisation of labour ward has also been looked at to give more time for one to one care, home and water births have increased and there is still ongoing debate about whether or not to have another birthing pool in the unit or several bigger, deeper baths.

The lead consultant has worked on a document, a risk assessment tool, to try to accommodate women who are classed as 'high risk' who for example might request a HBAC (home birth after caesarean). The document sets a picture of what the mother would like and what Jessop Wing offer and a plan is made. There is space for the woman, supervisor of midwives and consultant obstetrician to sign. This document reduces the doctors' fear of being sued for negligence and is, according to the Trust 'empowering for the woman'.

I have heard from women and midwives who have welcomed the risk assessment tool and I feel that the Trust are responding so much better to women's needs. For example, I was a doula for a woman recently who wanted a home birth. Her previous birth had been at home and it had gone well, until the baby's shoulders got stuck and even though the outcome was good this was seen as a risk in her current pregnancy. A risk assessment was carried out and this woman was transferred to a caseload midwife with the skills and confidence to support her wishes for a home birth.

things haven't got any worse, which is actually a huge achievement

The Results

The statistics vary from month to month, with swings in numbers, but overall the Jessop Wing CS rate remains the same at 24.5%. The Jessop Wing are pleased that it is slightly lower than the national average (24.6%) and that they have managed to contain it considering the rising rate elsewhere.

I personally feel a little deflated by the results but I am ever the optimist and it has certainly helped to get a constructive dialogue going, and to move the issue higher up on the agenda, and things haven't got any worse, which is actually a huge achievement.

The Future

There will be regular meetings to look constructively at the CS rate within a non-blame culture. There is a new consultant looking at developing a VBAC (vaginal birth after caesarean) clinic and a new consultant midwife who is responsible for promoting normality.

The Trust feels that indications for CS are unlikely to come down. I share this concern, for example, there is now a trial taking place in Canada to look at twin birth outcomes comparing CS to vaginal birth.[2] I feel that is it is just a matter of time before this will lead to most twins being born by caesarean, just as the discredited Hannah breech trial has lead to most breech babies being born by caesarean, and women struggling to find good support for vaginal birth with a baby in the breech position.[3]

The Hannah trial has been discredited for several reasons, but not least because it only compared planned caesarean section to vaginal breech delivery (sometimes referred to as breech extraction). Breech extraction is known to cause its own problems, and skilled midwives such as Jane Evans and Mary Cronk have shown excellent outcomes for mother and baby with normal physiological breech birth. Women should be able to access this option, and not be left with the choice between a medically managed breech birth or surgery.

there is a general contentment to continue to recommend elective CS

At an MSLC meeting we discussed that vaginal breech births were not being offered at the Jessop Wing and otherwise healthy women being automatically referred for CS. As a birth doula I have supported two women, over the last year, who were left with very little choice but to have an elective caesarean simply because their babies were in the breech position. Both of these women were expecting their first baby, both were young, fit and healthy and both were planning normal births until their babies were discovered to be breech.

There was general recognition that midwives and doctors need training to support women birthing their breech babies vaginally. I have included this on the Sheffield MSLC work plan for 2010 and I have been liaising with the lead consultant and Jane Evans to arrange 'A Day at the Breech,' in Sheffield. I feel that this is something that needs to be addressed urgently and has the potential to lower the CS rate dramatically.

The lead consultant informed us that there is a seven year cycle of specialist registrars. Consultants of a previous generation were trained and experienced with vaginal breech births but not anymore. However, there were 18 undiagnosed vaginal breech births, in Sheffield, during 2009 and they were all good outcomes.

The lead consultant informed us that he recently called a meeting with the other consultants, at the Jessop Wing, to see if he could gauge their feelings on vaginal breech birth. He informed the MSLC that there is a general contentment to continue to recommend elective CS. The unit would prefer to look at increasing the VBAC rate as they feel that this is a more achievable way of increasing normality and reducing the CS rate.

In addition there is an urgent need to look at the way Maternity Services are financed. At present Trusts are paid less for a normal birth than they are for a CS so there is no financial incentive to reduce the CS rate. The Trust would actually lose money if they started to reduce their CS rate, around £1500 for every normal birth it carried out instead of a caesarean. The NCT have suggested an equal tariff for normal and caesarean birth. AIMS would be interested to know what you think, so please contact us and let us know.

Finale

After almost three years in post I have now resigned as Chair of Sheffield MSLC. It has been difficult at times but my advice to anyone would be to stick with it as I am told that just being there is half the battle in itself. I have handed over to another AIMS member and I hope that things will continue to improve for local women.

I have been commended for my role as Chair and unexpectedly received a round of applause from everyone present at my last meeting. It takes time and commitment but can be very rewarding and I have thoroughly enjoyed my role as Chair; it has built my confidence and given me a greater awareness of current NHS practices. My reason for leaving is purely personal and I am sure I will be writing all about that sometime in the future.

I would highly recommend that other MSLC Chairs/user representatives push for their Trust to use the 'Promoting Normal Birth and Reducing Caesarean Sections' Toolkit, if only to help contain the rising CS rate. If your Trust hasn't got a copy, they can contact enquiries@institute.nhs.uk or 0800 555 550, quoting 'NHSIDQVToolkit-C-Section.

AIMS is thinking about facilitating a session where we can pool our ideas as to where to go next. If you would be interested in taking part please contact us.

Michelle Barnes
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Report

Payment by Results

Debbie Chippington Derrick asks if funding policy is financing a high caesarean rate

AIMS has been concerned for some time[1] about the current funding arrangement that mean the more caesarean and assisted births a Trust carries out the more the Trust is paid, and if there are also complications then the amount paid is increased further.

The table below gives details of the amounts paid per birth (2009/10).[2]

Type of birth	Amount paid
Normal delivery 19 years and over without complications	£1,174
Normal delivery 19 years and over with complications	£1,881
Normal delivery 18 years and under without complication	£1,177
Normal delivery 18 years and under with complications	£1,921
Assisted delivery without complications	£2,728
Assisted delivery with complications	£2,288
Caesarean Section 19 years and over	£2,579
Caesarean Section 18 years and under	£2,654
Caesarean Section with complications	£3,626

If a Trust reduces the caesarean or assisted birth rate then it reduces its funding, something that would cause considerable difficulties at all times, but even more so during the current economic climate.

NCT have recently raised concern about this issue[3] and given illustrations of the impact that a reduction in the caesarean rate from 25% to 15% on funding for a Trust carrying out 10,000 birth per year, showing there would be a loss of £1.5 million in funding. They suggest that the current tariff should be replaced with an equitable tariff, where the same tariff is paid for a normal birth, as a caesarean with complications. This would allow Trusts to implement policies to reduce the caesarean rate without the negative effect on funding and in the long term allow the Trust to be able to benefit in savings that will be made by performing fewer caesareans as they are able to change the associated provision of care.

Other groups have also expressed concern about this funding arrangement. Two articles covering this issue have appeared in the last two years in the ARM (Association of Radical Midwives) Journal.[4,5]

In the recent NCT article they also raised two other funding concerns. The first is the effect of the capital charge to each hospital; this is the charge made that is intended to provide funding for future building projects. Because this is based on the number of square metre that a department occupies, it means that no savings are made by providing home births and the provision of additional space such as in a birth centre costs the Trust money.

The second is the way the CNST (Clinical Negligence Scheme for Trusts) in England and Wales, and CNORIS (Clinical Negligence and Other Risks Scheme) in Scotland are implemented. The assumption is that risk is reduced by the use of interventions; and the use of them make it more difficult for a Trust to be sued. So, despite the fact that they often cause more harm than good, this provides an incentive for their use.

This legal and financial minefield continues to focus on the needs of Medical, Financial and Legal Professionals, and Trust Business whilst mothers and babies continue to be damaged.

Debbie Chippington Derrick

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Research

Debbie Chippington Derrick looks at what's in the evidence

Risk factors for uterine rupture and neonatal consequences of uterine rupture: a population-based study of successive pregnancies in Sweden

M. Kaczmarczyk, P. Spare, P. Terry, S. Cnattingius
DOI: 10.1111/j.1471-0528.2007.01484.x
www.blackwellpublishing.com/bjog

This study looked at all the birth records of women in Sweden between 1983 and 2001 which include almost 99% of all births; they took the records of all women who had two births during this period. They excluded 18,101 women whose second birth was a planned caesarean, and 9,399 women who had a caesarean for the second birth, but were unable to determine whether these were carried out before the onset of labour or not. This left a

group of 300,200 women, of which 24,876 had had a previous caesarean.

This type of study is unable to control for the difference between these groups, which makes it less reliable than a Randomised Controlled Trial (RCT), but it is a good sized study and RCT of this size would not be practical, so this is likely to be the best type of study to answer these questions. Women were only included in the study if the second birth was a live birth, therefore ruptures that led to stillbirths would not have been included.

Results for ruptures occurring during a VBAC attempt (most of which will be scar ruptures) are mixed, with ruptures occurring in women without a previous caesarean (which will usually be true ruptures of the uterus, although there is no information about other uterine surgery prior which may have increased the risk for the women). This seems a huge failing of this piece of research as it makes the results much less useful for informing decision making.

Not surprisingly the study found increased rates of rupture in women who had had a previous caesarean, 1% (1 in 100) compared to 0.18% (1 in 550); both of these figures seem high in comparison with rates from other studies.

They found rupture rates were increased in the group of women:

- that were induced, with a relative risk of 2.06 (1.48–2.86).
- with babies over 4kg, with a relative risk of 1.76 (1.32–2.35) compared with babies in the range 2.5-3.99kg. The relative risk for smaller babies was less, but it was not statistically significant.
- with pregnancies over 42 weeks, with a relative risk of 1.58 (1.09–2.28), however they failed to control for induction (despite having this information) which is likely to have been higher in this group.
- over 35 years old, with a relative risk of 1.78 (1.21–2.62); again what is not known is what other factor may have affected this result, as it is likely that the care of these women will have varied in comparison to younger women (more induction, continuous monitoring, immobility, etc.).
- who were shorter; for women under 159cm or shorter the relative risk was 2.09 (1.38–3.17), and for women between 160–164cm, the relative risk was 1.64 (1.14–2.37); again it is not know what other factor may have been different for these women.

The study failed to show any statistical difference between different BMIs, smokers and non smokers, different levels of education, those having instrumental deliveries, and different inter-pregnancy intervals.

A total of 274 ruptures occurred and 51 babies died. Although this is a high rate of death, it needs to be noted that 223 babies survived. Women are often led to believe that a rupture will necessarily lead to the loss of their baby, when this is not the case. We do not know what the rates of death were for babies when the rupture was of a caesarean scar and when it was a true uterine rupture. There were 51 babies who died and 50 ruptures occurred in an unscarred uterus; anecdotally the death rates are higher with these ruptures, but this study fails to include this crucial information.

There was also analysis of 5 minute Apgar scores which showed significantly worse outcomes for babies where there had been a rupture, which indicates that babies were less well at this point in time if a rupture occurred, which is unsurprising.

Infant and Neonatal Mortality for Primary Caesarean and Vaginal Births to Women with 'No Indicated Risk,' United States, 1998–2001 Birth Cohorts

MF MacDorman, E Declercq, F Menacker, and MH Malloy
BIRTH 33:3 September 2006

This American study used infant birth report and infant death records to make a comparison of outcomes for babies who were born by caesarean with those who were born vaginally when there was no recorded risk factor. The paper states that the records only include infant outcome and hence no comparison of maternal outcome was possible. It defines no risk factors as singleton vertex presenting babies, born between 37 and 41 weeks gestation, not reported to have any medical risk factors and for whom no complications of labour or delivery were reported on the birth certificate, and they give an extensive list of medical factors which were excluded, which was reassuring.

This left a study group of 6,073,964 births and 13,009 infant deaths. Infant death rates in the whole population were 6.99 per 1000 for the period the study considered. This group of low risk cases had lower death rates; the rate for vaginally born babies being 2.06 per 1000 and the rate for caesarean born babies 3.56 per 1000.

They only had reason of death for the neonatal deaths, around a quarter of the deaths, and they seemed to happily discount the importance of the post neonatal deaths on the on the basis that 'the choice of method of delivery would be expected to be more strongly related to infant health in the period immediately following the delivery' which seems a very naive and unprofessional assumption for the researchers to make. They then stated 'For this reason, the subsequent analysis in this paper will focus on neonatal mortality' when in reality it seems this was due to lack of data.

The neonatal death rate for caesarean born babies was nearly three times higher. It could be that these increases are solely due the type of birth, however, increased death rates for congenital malformations, deformations and chromosomal anomalies were found in the caesarean born group, and although it may be possible that some of these babies may do better if born vaginally it does lead one to question how reliable the low risk assessment was in this respect, and hence the validity of the results of this paper.

Debbie Chippington Derrick

Jeremiah Jacob

Nataliya Huxley shares the experience of deciding on a repeat caesarean

From the day I found out I was pregnant; I started to plan my home birth. Not just any home birth, a Home Birth After Caesarean otherwise known as a HBAC.

After my initial appointment at the hospital, I explained that I was planning a HBAC; the booking appointment midwife said it would be unlikely I would be given permission to birth at home, due to my previous caesarean and the fact I had also torn and had a post partum haemorrhage. I was very determined not to be pushed into a hospital birth and to get what I wanted for my baby and myself. I sought help from AIMS and found a support group online; the women I met here had been through what I had and, with their experience and knowledge, I started on my mission to get my right to birth at home satisfied. I wrote to the Prime Minister, I wrote to the Chief Executive of the hospital, I wrote to the Supervisor of Midwives. I got replies from them all bar the Chief Exec!

I got my right to HBAC and support from the community midwives. Each visit was met with the same, 'But you had an emergency section last time and a bleed.' Every visit was met with anxiety the determination to put me off.

Quite often at the end of a visit the midwives would compliment me on my knowledge of facts and the strength to fight for my rights, saying most women back down or just don't even bother to attempt to go for what they want, out of pure fear of rejection. I was always so proud that I was getting closer to my hopes and dreams of my HBAC.

As my due date approached I grew anxious he would be late, adding pressure to the already delicate situation. At 40 weeks the midwife came and announced I was now at term and still pregnant; I pointed out pregnancy actually can go to 42 weeks, all the while thinking I am so not going to be one of those women!

She offered me a stretch and sweep. I declined. I was only just 40 weeks, although according to my dates I was 41 weeks, and the temptation to get one was huge. I was very uncomfortable and in pain daily. I had been in pre-labour for about 3-4 weeks and desperately wanted to give birth, yet wanted it to be natural and to not mess with nature. She arranged for me to have a post-dates scan for 10 days post EDD I was OK with this as I was certain he would be born before then.

10 days post due date

After much thought I decided that I would rather let nature take its course and after speaking to the midwife she said that the appointment would also be to arrange my elective section. That scared me and I said, 'But I don't want a section, I haven't fought for this long and waited to have an elective.' So, I cancelled the appointment and decided if I was still regnant at 42 weeks I would get a scan then, but I was going to wait regardless, I would only book a section if the placenta was deteriorating or the baby was in stress.

At about 11 days post-dates I had a huge breakdown and cried my eyes out to my partner Unal, claiming I couldn't take any more and that I wanted an elective. I couldn't take being in pain and having so many false starts; it was starting to affect me mentally and my body was tired. He calmed me down and reassured me I was doing just great and presently not in the right frame of mind to make a choice of what was going to happen. With that he sent me off to bed to sleep and think about it the next day,

12 days post-dates

The next day I rang the midwives and asked them to come and visit me. I arranged it for a Sunday so my husband could be there. I had no fight left in me and knew if they were pushy I would give in. The midwife that came was very nice, she did push for another stretch and sweep but again I declined. I explained to her I didn't want to be induced and have a failed labour and another emergency section, and if it came to that I was booking an elective. She was quite shocked but wrote it down anyway. I agreed to a scan for 14 days post dates.

14 days post-dates and the day of the scan I decided I was going to book an elective section and aim for the most positive outcome I could. I wanted a maternal assisted caesarean section. I went along to the scan with my closest friend and Eliza, my two-year-old daughter, for support. I was checked out and it was decided I would return to the hospital the next morning at 8am and my caesarean would be carried out that day. I was thrilled, to be honest, as I was in control as much as I could be anyway.

After so many false starts, being in pain daily and taking care of my daughter, I think I gave up hope, and Unal said he'd support me at this point as I was just a mess!

Wednesday 11 June

With my bags packed and a few nerves Unal, Eliza and I got into a taxi and headed off to the hospital. We arrived at 8am. We checked in and waited. My friend Jen turned up; she was there to be a support person for Eliza who we still wanted to be involved as much as possible. My sister turned up at 11ish and was also there to help with Eliza and to be there for the birth.

We all went to a café where everyone enjoyed a drink, except me as I had to fast for surgery. We went back and were told that my op would be at 2pm, so we headed to our room. Jen, Lara and Eliza weren't allowed into the ward at this point so they took Eliza for a walk and a sleep. Unal and I went and spent the last couple of hours

on our own. We reflected on our journey so far and were both really at peace at our choice to have the section. At 3pm they called for me to go to theatre. Off we went in true glamour style of theatre gowns and support stockings.

Upon arrival at the OR the anaesthetist came and spoke with us at great length; she explained the whole epidural spinal procedures, she provided statistics on the dangers - she said of course they are there and they happen. I actually started to feel more fear then! I ran through some questions I had and explained what I wanted to happen in regards to an emergency.

I showed her my birth plan, I really wanted a maternal assisted section and although I knew not everything was possible I knew most of what I wanted could be accomplished. She agreed, the only compromise was handing him to me over the sterile field. I was fine about that not happening, as long as he came to me before anything else was done.

I was in control as much as I could be

I sat up on the table for the epidural. I zoned right out and breathed deeply. I focused on a tree in my mind and away she went, explaining every step and what sensations I might feel. I talked through them as it happened and it was done. They lay me down and waited a few minutes then they did the cold test to see how numb I was; all was good and they set to work.

Within a few minutes I started to feel nauseous. Because of the memories of Eliza being born and the nausea which was indicative of my haemorrhage, I spoke up and said I felt sick and to give me maxolon now! She waited and said it might make me feel more sick. After a few minutes I said 'I'm going to die' in my mind and I spoke up again. I asked for maxolon and they gave it to me.

I once again zoned out. Unal was stroking my hair and I heard him say, 'did you hear that!' I didn't respond but I had heard a slight screaming baby sound so I opened my eyes, they had already dropped the screen down and were pulling him out. His head was out, I could just see it. The screaming got more evident and he was making his arrival known, and with a final pull he was out and held straight up to me to meet him. He peed immediately and I was extremely lucky not to get a face full! I was told, 'That's what you get when you ask to see your son being born!'

I had no tugging, the room was quiet, no one said more than they had to. It was very peaceful.

His cord was still attached and blue and they let it stop pulsating before they clamped it and took him off to be dried and wrapped in a warm blanket. The nurse took my gown down so I was fully exposed and they handed him to me, un-wrapping him so he got skin to skin contact. He was so warm! I started to talk to him and he calmed down. I was so emotional I could barely talk and could not stop looking at him, he felt so tiny in my arms. Unal was right there beaming away as they congratulated us. After about five minutes it started to get awkward holding him, so I said for Unal to take him, which he did. I asked that he got weighed at that point and dressed. Off they went. I closed my eyes and was just thrilled with how things had gone so far.

I then heard the nurses and doctors talking about his weight, and how they thought he was huge but not that huge. I asked how big he was, '10lbs 1oz,' the porter said. I was thinking no way, there is no way I was carrying a baby that huge! I asked again, same answer. Unal came back and handed him back to me, I asked him what does he weigh? He said the same thing! I couldn't believe it. It was quite hard holding him lying down so he went back to his daddy. Within 10 minutes I was all sewn up and ready to go to recovery.

They got me into a bed and gave me my baby and said, 'No need for you to go to recovery. Everything went so well, so we shall just take you to a private room to enjoy him?'

WOW! No recovery. I was OK, I didn't nearly die, I had the most amazing caesarean and I was going to a private room to be with my newborn son and to meet back up with my family and friend. I said, 'Really? My family can come in now, 40 minutes after he has been born?'

Unal went off to collect Eliza, my sister and friend.

My friend Jen walked in the room, I was overcome with emotion at being able to share this time with her. She has been the most amazing support and friend my entire pregnancy, to see her was very exciting and I handed Jeremiah over. Into the room came a very excited Eliza and my sister; more tears of joy!

More cuddles from everyone and shock and disbelief I was OK and not dying!

Eliza climbed up onto the bed and met her brother for the first time. She said, 'Mya came out!' She fully understood and gave him a kiss, it was at this point he started to cry so I decided to try and latch him on This was a concern of mine as Eliza was still breastfeeding. He went on like a pro and Eliza was fine about it all.

So, all in all, I had the most amazing experience. It couldn't have gone better. It was all I could have hoped for and more. I had a great team of doctors (all female) and support network around me.

I came home after two days in the hospital. The doctors were amazed at my mobility and recovery.

I am in no way disappointed about not having a HBAC. I was worried I would be but I'm not. My son was born in a respectful manner in a controlled environment where my wishes were carried out. I am thrilled.

Welcome Jeremiah Jacob!

Nataliya Huxley

Giving birth according to hospital protocol

Deborah Lickfett describes the difficulties in that process

My pregnancy was a happy one without any complications. I was looking forward to giving birth naturally and dreamed of welcoming my baby girl in a birthing pool in the newly refurbished birth centre at UCLH in London. After a straightforward pregnancy, I was hoping for a straightforward birth.

The first 'problems' surfaced when I went past 40 weeks. Accompanied by my husband, I went to the post-dates clinic for scans and monitoring - all of which turned out completely fine. It was there that I heard the magical phrase 'because it is hospital protocol' for the first time.

Going over the scan results and confirming that all was well, the midwife said: 'So we do a sweep now and book you in for induction on Monday.' I simply said, 'No.' She looked a bit puzzled and started her monologue: That the procedure was UCLH protocol; that they never ever let anyone go over 42 weeks; that post-term pregnancies increased the risk of stillbirth, that there could be meconium in the umbilical fluid, etc.

We were trying to give her some smart answers – we had done our homework, too – but there was just no stopping her. 'But I thought there was the option of being closely monitored instead of being induced, when all was well?' I asked sheepishly. 'But that would mean you needed to speak to a consultant, and I don't think that they would let you go over 42 weeks,' she replied. I insisted on seeing a consultant and, after a while, she finally agreed to give us the right to make an informed decision - which we should have had from the start - and went to get a consultant to see me.

paid for with a health threat for our unborn daughter

By then I was trying hard to fight the tears of frustration and anger. I couldn't believe that she was trying to trick me. Not only did she withhold the option, she was trying to make it sound like an absurd idea.

The consultant went through all my previous results and said 'I think you are sensible not wanting to be induced. To avoid one stillbirth, we are inducing more than 400 women in the UK. This is totally out of proportion.' I was gobsmacked. Even more so when she went on about childbirth in the UK and how it was being over-medicalised. She told me about her own experience, having had three membrane sweeps to get things started and finally a natural birth without intervention. Finally someone who not only listened, but also seemed to understand. I decided to have the sweep.

We left the post-dates clinic feeling disillusioned, to say the least. Apparently it makes a huge difference who you meet, if you want to be treated as a person with individual needs.

The next days were exhausting. I felt immensely under pressure to perform according to hospital protocol. I wanted to avoid being put on a drip and to risk the follow-up measures that are too often leading to a highly instrumentalised birth.

After a few days and two more membrane sweeps, I was only dilated by two centimetres. The amniotic fluid had started to diminish. Apparently, one of the sweeps had caused a little hole and some leakage. After a long day of sitting around at the clinic and waiting for scan appointments, I was admitted to the hospital and finally agreed to be induced. This meant that my birth of choice in a pool at the birth centre was no longer an option. The cost of a natural birth seemed to be too high when paid for with a health threat for our unborn daughter.

When I was monitored again, regular contractions started to show. The midwife suggested to give me some time and see what happens. Unfortunately, his shift ended shortly after that.

The new midwife barely looked at me as she came in and started unpacking her instruments. Despite the agreement we had made earlier on and clearly stating that we wanted to delay induction as long as possible, she insisted on examining me again and, while doing so, said that she would break my waters now. She already had everything ready, the hook placed next to her. I was shocked and amazed that she would not only disregard what we had agreed on earlier, but intended to act exactly contrary to my expressed wishes. Had I not queried what she was about to do, she would have induced me without my consent.

We started a pointless discussion, my husband, my doula and me against her. All our questions were answered with 'because it is hospital protocol' or 'because you are here to be delivered, so we deliver you.' In the end, after an emotional, hurtful and frustrating discussion, she accepted she would not convince me and sent a consultant in.

Surprisingly, the consultant did not have any problem with giving me more time as long as things were progressing. In fact, she was very understanding.

The three of us went for a walk outside and came back to have a nap. I was hugging my husband on the hospital bed, just wanting to go home. And that is when my waters broke, all by themselves, on the day I was supposed to be induced. I was so relieved. My contractions got very recognisable and much stronger.

The midwife came in and examined me - again, and despite the consultant agreeing on another six hours for me to progress without intervention, she placed all her instruments on a tray next to me to be ready to do whatever she thought was right. She said there were still membranes and that not all the waters would have gone. (Another midwife and the consultant confirmed later on that this wasn't true.) By that time I had totally lost trust in her; her touch on my skin made me cringe and scared me. I simply did not believe her any more.

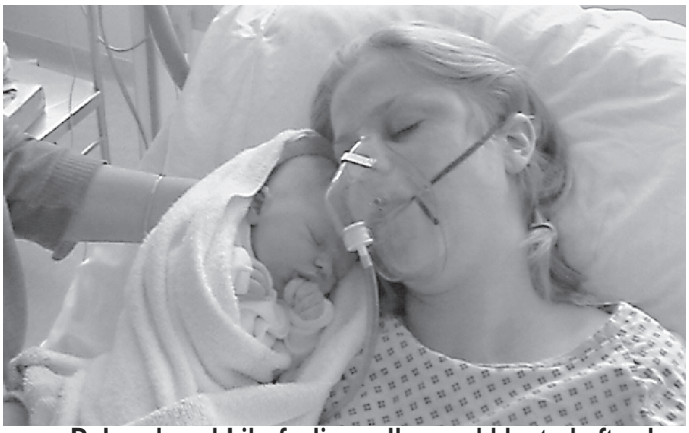
Although I had made further progress (cervix went from posterior to anterior), she said she had to rupture those membranes. We were again starting a discussion, us stating that we agreed with her and the consultant on another six hours without intervention and her, that I would be in hospital for induction and to be delivered and that the protocol states... During all that time, she had her fingers in me and was holding my cervix in a tight grip. She caused me physical pain that I could feel even through the ache of several hours of contractions. I got extremely upset and angry. I only freed myself of her grip by jumping backwards on the hospital bed.

I never felt as abused, humiliated or vulnerable as I felt in that very moment. The midwife didn't only ignore what I needed or wanted, she also ignored what was agreed on earlier by other health professionals, and only wanted to go forward according to her own plans. My doula, a woman with considerable experience, and my husband, who is usually not easily shocked, could not believe the midwife's inconsiderate, harsh and un-empathic behaviour. Sadly enough they were at this point too paralysed to protect me or to put a foot down and end to the ordeal by having her replaced.

When the contractions got very intense and I could hardly catch my breath in between, my doula wanted to organise for me to have a bath. She looked for the midwife, who claimed not to know how to run the bath, and only managed to get me in because she was very persistent.

In the bath, the pain was more bearable. I was far from slowing down, but also I had in the back of my head 'have to make progress, have to make progress'. The midwife continued to interrupt us, wanting me to get out to examine me again after a short while, but all three of us shouted, 'NO!' as soon as she peeked into the room. My doula finally and shyly offered to ask for the midwife to be replaced, but in the state I was in, I just wasn't up for any confrontation or hard feelings.

After six hours of very intense contractions, I decided to be examined, but asked for a second opinion. There was no way I would let her touch me again. Another midwife came in and told me, I still was only two centimetres dilated. All of a sudden, I couldn't handle the pain anymore and asked for an epidural. The thought of going on like that without progress was devastating. I was hoping to get some sleep and be able to relax and dilate further. Also, 'our' midwife had only two hours left on her shift, so I would have got rid of her by the time next steps would have been needed to be discussed.



Deborah and Lily, feeling yellow and bloated after her caesarean

When the epidural kicked in, I felt the tension coming off me. Just as I wanted to surrender to a good, proper cry, the consultant we had met earlier that evening came in and said, she was sorry, but the monitor trace showed that the baby's heart rate dropped with every contraction, and she suggested in calm, informative but no uncertain terms that a c-section was strongly to be recommended at this point. We agreed without hesitation. Apparently we still had a little time and they topped up the epidural to prepare me for the section.

While in the operating theatre my baby's heart rated dropped even further and did not come up anymore. Within a matter of seconds my husband was thrown out of the theatre and I was put under general anaesthetic. My baby daughter was delivered minutes later by emergency caesarean.

At 57 cm and 7.5 lbs, she was far from being overcooked. No curled nails, no meconium. She even had a little bit of lanugo and vernix left. She cried her first cry without any help and did not need any suction.

Looking at Lily today makes it all worth it. But still, I believe that I – and every other woman to give birth - have more rights than holding a healthy baby in my arms. After I cared for and nurtured this little creature inside my womb for more than nine months, a healthy baby is mainly MY achievement. I had hoped for more than getting her out safely from my birth experience.

I believe that pressure, stress and thus adrenalining played a crucial role in my birth experience. Who knows how it could have been, if I hadn't been in fight-or-flight mode all the time?

I want to be treated with respect and dignity, as a human being with rights and a brain, not like a piece of unresponsive meat that can be forced to react, feel and give birth in line with hospital protocol.

Deborah Lickfett

Reviews

The Faceless Caesarean

by Caroline Oblasser
Edition Riedenburg, Austria 2009
ISBN: 9783837075601

This book, written by mothers for mothers, also has much to offer the medical profession and anyone working in the maternity services.

The author conducted a survey questionnaire of 162 mothers, the findings of which make interesting reading and are summarised in the first part of the book. The main part of the book is centred around 60 of the responses and enables the voices of these mothers to be heard, placed in the context of brief details of their caesarean births, and accompanied by a black and white picture of their scar on the facing page.

I very much liked the fundamental grass roots reality of the book and the wide range of views and approaches to caesareans that are expressed by the mothers themselves. The women are faceless and nameless and yet their different characters, perspectives and views still come across very strongly; they are anonymous but still very real individuals.

As far as I am aware this is the only book to include photographs of the women showing their scars and I found the pictures very interesting. Caesarean mothers have a natural curiosity about how their scars compare with others and it isn't often that we have an opportunity to make such assessments.

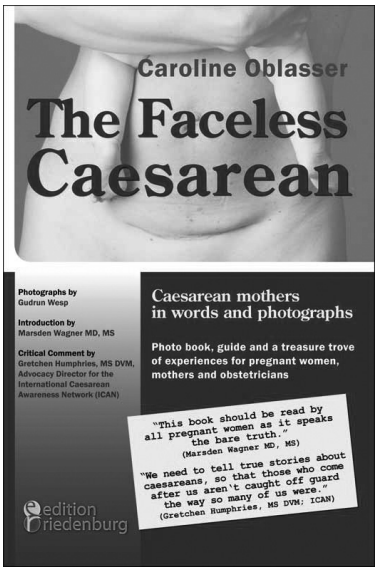
The survey was conducted among women in Germany and the book has been translated which has given rise to one or two odd phrases and strange terminologies. One of the survey questions asks if the caesarean was 'prognosticated' which my dictionary informs me means 'foreseen'. However it is still understandable and I found the slight oddness added charm and a sense of communication on common ground with another country.

The book also contains a photo report of a caesarean section, giving a running commentary linked to a series of black and white photographs which are shown in a separate sequence to the commentary. This is a very sensitive way of presenting this chapter as, like many caesarean mothers, I actively avoided such information for many years. However some women are interested to know what actually happens from an operative point of view and this format gives the reader a choice of whether to just read the commentary or to view the pictures as well.

There are occasional inaccuracies in the book. For example, in an introduction by the Advocacy Director of ICAN, reference is made to 'the apparently shallow choice of a pop-star in the UK to schedule non-medically indicated surgery.' Every time I see this widely quoted reference to 'too posh to push' my sense of injustice is renewed. It takes no account of the standard medical advice that Posh Spice would undoubtedly have received as a slim size 8 with a breech presenting baby who went into labour before the date of her scheduled caesarean section. Personally I suspect that far from being 'too posh to push' she was infinitely more likely to have been 'conned and cut' like so many others.

This book has a richness of experience, and the words of these German caesarean mothers reflect the words of caesarean mothers worldwide. The realities of caesarean birth are voiced without being sensationalised, trivialised, promoted or denigrated, giving a sense of what it is like to undergo caesarean surgery from those who have experienced it. It answers the question 'What is it like to have a caesarean?'

Gina Lowdon



Caesarean Section, Understanding and Celebrating Your Baby's Birth

by Michele Moore and Caroline de Costa
John Hopkins Press (2003)
ISBN: 0-8018-7337-1

Given the title of this book, and the statement on the front cover that 'Trusted physicians reassure mothers and mothers-to-be: It's okay to say yes', I had high hopes that here was a book that would cover Caesarean Birth in a positive and supportive way.

There is a great need for information on caesarean birth that can balance the campaign to reduce caesarean section rates to acceptable levels and put into perspective the accompanying media coverage that highlights the risks and consequences to both mothers and babies of caesarean operations.

Unfortunately I don't feel the book lives up to the promise made by its cover.

Whilst the cover proclaims, 'It's okay to say yes', this book does not pretend to support the growing number of women who express a preference for caesarean birth. The authors claim that maternal request for c-section is exceedingly rare in the United States or Australia but common in South America and increasingly so in Great Britain. They further state that: 'This book is not about this option.' So it's okay to agree with your doctor, but not okay to have your own opinions and needs.

Mothers struggling to come to terms with an unexpected or traumatic birth, many of whom would dearly like to be able to 'understand and celebrate' their baby's arrival, are also unlikely to find much in this book that will help.

The basic message is that 'doctor knows best', that every caesarean is necessary, and that 'the major point is that all of these c-sections are done for good medical reasons.' The authors feel that to lower the current caesarean section rate (CSR) would put mothers and babies at risk. There is no evidence to support this theory however, and the statistics simply don't add up. The World Health organisation (WHO) have stated there is no justification for a CSR above 10-15% - the upper figure only being added following the outcry from the Americas that a target set as low as 10% would not be taken seriously in parts of the world with the highest caesarean rates. A Guide to Effective Care in Pregnancy & Childbirth (2nd edition) states: 'The optimal rate is not known, but from national data available, little improvement in outcome appears to occur when rates rise above about 7%.' Clearly then, with a national rate of 24%, a large proportion of caesareans cannot be justified on grounds of safety – a fact this book fails to acknowledge.

There is little in the book that I would consider helpful to a mother wanting to understand why she needed a caesarean. The explanation that caesareans are necessary because 'nature' gets it wrong or 'does not cooperate' is woefully inadequate. Unfortunately the predominant attitude is that caesareans are necessary because the doctor has judged it so and the suggestion is made that women would do better to 'put faith in their ob/gyn not nature.' These 'explanations' are too superficial for many caesarean mothers who may be wondering why nature didn't cooperate or in what way nature got it wrong.

There is also no explanation that all 'emergency' caesarean sections are not in fact dire emergencies – an emergency caesarean is described in the book as 'one that is urgent' and 'is done to save the life of the mother or baby.' There is much confusion and misunderstanding of the terms 'elective' and 'emergency' and both The National Sentinel Caesarean Section Audit Report and the NICE Caesarean Section Guideline have recommended that all caesareans be classed according to four categories of urgency – only category one (often recorded as a 'crash' caesarean) is classed as 'an immediate threat to the life of the mother or fetus.' In the Audit report this category accounted for 16% of caesarean births, which is only around 3.5% of all births.

I was also disappointed at the lack of 'celebrating your baby's birth.' Obviously a healthy mother and baby are cause for celebration, but there are other aspects of caesarean birth that could be celebrated as well. There is no information on, or suggestions for, improving the experience of caesarean birth, which I find a glaring omission in a book with such a title.

Although both children of one the authors were caesarean-born and the other has given birth to seven children vaginally, the book is written very much from the doctor's point of view rather than the mother's. The book informs women of what will happen rather than offering or suggesting options.

It was worrying that in all the accounts of caesarean births in the book the babies seemed to leave theatre with partners just after the birth, leaving mothers alone on the operating table. There is no indication that this is not always the case although the book does say that general anaesthetic is used for most emergency caesareans (no longer the case in the UK and I would be surprised if it is in most places in the USA either). There is also no acknowledgement that the woman may need support during this time, let alone mention of adverse affects on bonding or breastfeeding, or the psychological consequences of separating mother and baby at such a time without over-riding medical need. Providing the baby does not need specialist paediatric care, and most caesarean-born babies don't, then normal procedure ought to be to lay the baby across the mother's shoulder, on her chest, or have her partner hold the baby close by her. The 'sewing up' part of the operation goes much more quickly and pleasantly when you can pass the time baby gazing!

Apart from the general tone I found some aspects of the book concerning. Some of the opinions and views expressed (many as implied fact) lead me to question how research-based this book is, especially as there is not a single reference in the entire book. 'Trusted physicians' the two authors may be, and perhaps as such they do not feel they need to reference their book, but it is unusual today for books of this nature not to include full research references and sources of further information.

Several highly emotive but somewhat questionable links are made, reinforcing common misconceptions, which do not help, and may even hinder, an understanding of the real situation. Historical maternal and fetal death rates are linked to today's high caesarean rates with the statement 'caesarean births represent births that, before modern obstetrical practice, often resulted in tragedy.' A similar link is made between high maternal and fetal death rates in non-industrialised countries with caesarean section rates in the western world. Whilst the facts are true there is no proven or even indicated correlation.

There is no mention of the improved living conditions, sanitation, and better diets that have played such an important role in lowering death rates of people of all ages, increasing child survival rates and reducing maternal and fetal death rates. Those of us living in western industrialised countries are quite simply healthier than previous generations and our less fortunate sisters in other parts of the world. Also, as discussed previously,

there is no statistical evidence to justify the need or benefit for caesarean section rates over 7%.

Whilst the risks of caesareans are not ignored, the language used trivialises them. By contrast much is made of rare adverse consequences of vaginal birth. Personally, I don't feel it is helpful to use rare circumstances to explain and justify actions taken in situations that are commonplace. Again, the statistics don't add up.

For example, 'failure to progress' is explained in terms of fistula and the claim made that few women in the developed world suffer these due to caesarean section. Whilst this is in part true as fistulas are rare in the developed world, the implication is that the large number of women who undergo caesarean section due to 'failure to progress' in labour are being saved from severe and debilitating forms of incontinence. Again, there is no clear evidence that this is the case.

Rates of postnatal depression linked to vaginal birth are quoted of 10-50% with discussion of a study (not referenced) of women in war torn Lebanon. Clearly the authors do not understand that research based on one set of criteria is not always applicable to another. Not surprisingly there is no mention of PTSD (post-traumatic stress disorder), linked to either vaginal or caesarean birth.

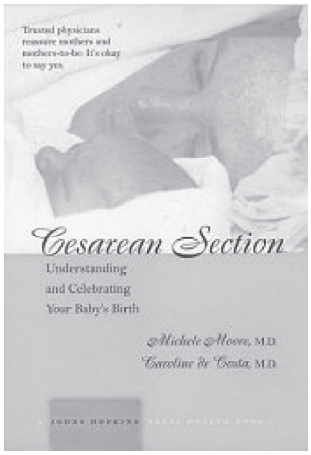
Another statement that further demonstrates the lack of balance in the attitudes of the authors claims: 'studies have shown that in the first six months after their first vaginal delivery, approximately 85% of women have some discomfort in [the vaginal] area. For a woman who has a c-section her incision may trouble her for the first six weeks but generally not after that.' The studies referred to are not referenced of course and therefore the reader cannot verify their validity. I personally found the high percentage quoted difficult to accept as I know a great many mothers who have given birth vaginally and am not aware of any that have problems of this nature. In my 16 years of supporting caesarean mothers I can testify to the fact that unfortunately many women are 'troubled' by their scars long after the 6-week check, an unfortunate few suffering long term pain necessitating regular pain medication months or even years post-caesarean.

In common with a significant proportion of obstetricians, the authors believe that 'c-section in itself poses fewer risks to the baby than vaginal delivery does.' The balance of risks does tend to depend on which risks are added to the scales though. One risk rarely considered is that of the baby getting cut. Two studies have now put this risk at around 1%. Also rarely taken into consideration are risks to subsequent babies – the safest way to be born is to be a second vaginally born baby. I know from my own reading of research that long term risks of caesarean section tend not to be taken into account as research is rarely carried out due to its lengthy nature and difficulties getting funding, however there is some evidence that caesarean-born adults are more likely to suffer breathing problems such as asthma.

It is clear too that the authors have little appreciation of the profound psychological impact of birth, both by caesarean and vaginally. Comments such as 'women may be disappointed with having a hysterectomy' and a case report comparing feelings of a woman who lost her baby due to caesarean scar rupture (a very rare event) to those she felt after her caesarean, clearly demonstrate the sort of lack of understanding women meet from medical professionals all to frequently.

Sadly, I cannot recommend this book. The authors fail to demonstrate any real understanding of caesarean issues and I have doubts over the validity of the research base and the conclusions drawn.

Gina Lowdon



Vaginal Birth after Caesarean

by Helen Churchill and Wendy Savage
Middlesex University Press (2008)
ISBN-10: 1904750214
ISBN-13: 978-1904750215

This book, prefaced as 'The VBAC handbook' is a small book, with pages 7-39 taken up with factual information such as the risks of VBAC and repeat caesarean, VBAC success rates and so on, with the bulk of the book being taken up with seven VBAC success stories.

I found this book to be a strange mixture of ideas, tone and language. Despite a note about using empowering language at the start of this book, the language flits between medicalised and involved, to vague statements which do nothing to enhance women's understanding of how birth works, such as 'women report that when you are able to move around in labour it helps your labour to progress.'

Rather than long sections of text about percentages of women who wished to have their baby by CS or vaginally, I think a short section explaining how the pelvis works would be much more empowering to women considering VBAC and has far greater potential to make VBAC a reality. Equally, the images used are poorly chosen (there is one picture of birth in the whole book and this features a woman being passed her baby in a semi-recumbent position.) In a book with images, it would have been nice to use those which support the ideas in the book rather than reinforce the current norms of medicalised birth culture in the UK.

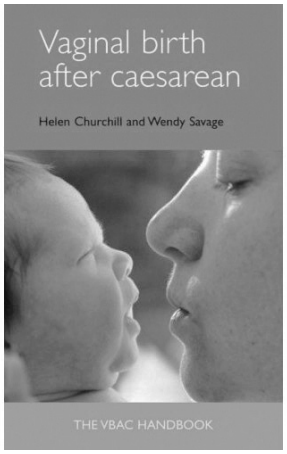
The second section of the book contains seven VBAC

stories, varying in location, care-givers and number of prior caesareans. This could be a great eye opener for some women, who are just setting out on their VBAC journey and finding out what is possible with support and preparation. However, I wonder if women who have been told after their second (or third, or fourth...) caesarean that vaginal birth after multiple caesareans is not 'allowed' would even pick up a book entitled 'Vaginal Birth after Caesarean' so as to discover what other mothers have done. I feel that to normalise the safety of vaginal birth after more than one caesarean, our language needs to start honouring it as a possibility.

These are just a few examples of how the book appears haphazardly thrown together, without a clear purpose. There is a lot of useful information in this book that if more cogently and cohesively presented could be an excellent starting point for women who are not well informed about VBAC, but it is certainly not 'the VBAC handbook.'

For a similar price, I would recommend the AIMS publication Birth after Caesarean which has a more woman-friendly and empowering approach whilst packing in the same, if not more, information.

Sarah Stenson



How to Avoid an Unnecessary Caesarean

by Helen Churchill and Wendy Savage
Middlesex University Press (2008)
ISBN-10: 1904750168
ISBN-13: 978-1904750161

This book, which has the subtitle 'For women who want a natural birth' is a small book, which balances factual information and some less usual birth stories.

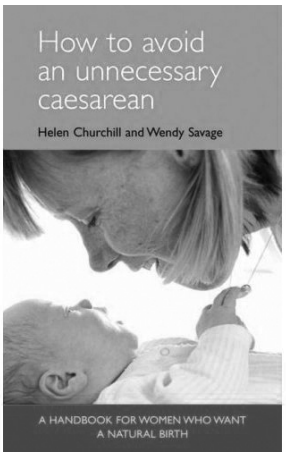
This book has potential to be a useful starting point for women who are learning about birth technology and the current norms in Western birth culture, particularly women in the UK, as there are sections discussing the differences between NHS care and independent midwifery. It discusses the historical rise in caesarean section deliveries compared to relatively recent times, and some of the contributory factors such as the prevalence of hospital birth and continuous electronic fetal monitoring. It provides a starting point for examining how standard obstetric policies can make straightforward birth less likely than evidence (and indeed common sense) suggests it ought to be for healthy women and babies at term.

The book contains some information about the physiology of birth such as an explanation of the idea of Optimal Fetal Positioning, and breech birth is also discussed. For these matters to be fully considered further reading would definitely be needed. Likewise, although this book states it is 'for women who want a natural birth,' this is not a toolkit of coping mechanisms for labour - simply providing explanations of how epidural anaesthesia can make straightforward birth less likely, for example.

The birth stories featured provide anecdotal evidence and support for women planning vaginal birth where many women would have a caesarean, often through lack of information or support. I find it slightly strange that amongst these, there is an emphasis on breech birth in particular, which in my opinion is a shortcoming of the book, since only 3-4% of babies are breech at term and many more 'unnecesarians' are performed for failure to progress, for example. Stories where women have declined interventions and had normal, though long, labours would have been really inspirational and begun to dispel the narrow range of 'normal' that NICE and Trust policies would have us believe in.

This book, like its VBAC counterpart, is a starting point and unlike the VBAC handbook, I believe this book may have captured a useful niche in the market. In my opinion, it has most potential to enable first time parents to consider their decisions carefully, although strangely I wonder whether the direct title may unfortunately make it less likely to be read by that target audience as the sense that the system does not work for them is often not always understood until after their first birth. I would be interested to hear from women who have read this book as part of their birth preparation and understand how or if this has influenced their decision making and birth outcomes.

Sarah Stenson



Publication Alert...

AIMS is now stocking **The Father's Home Birth Handbook** by Leah Hazard. A must for fathers-to-be or birth partners. £8.99

Struggling for Support

I was wanting a VBA2C and had already had one very unhelpful appointment with my consultant. I decided to seek out more information and prepared myself thoroughly for the next appointment.

My appointment was actually quite funny really. I saw a different registrar from the last time, a young Indian woman and I think I scared the pants off her to be fair!

I had decided I wasn't going to put up with anymore bullying and was on a mission, unfortunately for her she was the one who got both barrels. I quite plainly told her in no uncertain terms that I was going to do this my way, and my way only. She tried to talk me into going into the consultant unit, saying that the midwife unit wouldn't allow me in.

When I laughed and said, 'No chance,' she backed right off

Then she said I'd have to be constantly monitored, and as soon as I got there a venflon would be put in me. These were just two of the things I knew I didn't want, and that I knew would lead to me being strapped to a bed. When I laughed and said, 'No chance,' she backed right off and said she wanted me to see the consultant midwife. I think she thought that the consultant midwife would be her ally, but she couldn't have got it more wrong.

The consultant midwife called me to make an appointment and I told her before she started to speak that if she was going to try to bully or scare me I was putting the phone down. She burst out laughing and then went on to tell me how she felt about this kind of consultant, and that she was here to help and support me in my choice of a home birth. Hopefully I have found a midwife that will try and help me, and I am meeting up with her in August to go through everything from start to finish. I feel so much better about things knowing that not all of the medical staff will be against my decision.

Clare

Healing and Trust

Now don't for one moment get me wrong in any way, my VBAC was the most amazing, wonderful experience of my life but there is always one thing that will taint it. I look at my eldest son and now KNOW rather than suspect that what was done to us both was negligent, barbaric, dangerous and wrong. My heart bleeds every time I think of the trauma I suffered and the fact that we were basically robbed of our first few weeks together because I felt like I had been in a car crash. Jack is a year old today and I love him more than life itself as I do Tom. I just feel so sad and so angry when people say, 'Gosh! Well done having a baby at home, aren't you brave.' What is brave about staying at home letting nature take its course, walking away from it unscathed, without penetrating abdominal wounds and with your sanity intact?

I used to want to hit people who would look at Tom when he was a baby and say, 'Didn't you give your mummy a hard time?' It wasn't him, it was the 'professionals' who tortured me for three days before they cut me open who gave me a hard time, not my beautiful boy who was put in so much danger and never did anything to deserve it.

My HBAC was wonderful. It was also easy and it was normal and I never, to be honest, doubted my ability to give birth. My doubts lay with the intentions of my care givers and I did not truly trust anyone not to hurt me or my baby until after Jack was born. I never doubted my ability to birth Tom, I was manipulated and bullied into a course of action which made the outcome inevitable. I don't think I will ever truly be able to put my demons to rest about Tom's birth. I am so incredibly lucky though in that I have a wonderful IM who I can just about afford this time around and this time I truly trust her completely. I feel great and as much as I don't want it and would be desperately disappointed I know that I would be OK with a CS this time around as I trust my midwife and I know it would be for a sound medical and unavoidable reason and would be lucky to have obstetric care available to save me and or baby.

Sarah

Hope for Albany

Thank you AIMS for supporting The Albany Practice. I gave birth in a birth centre where I used to live and it was amazing. The midwives really cared about what we wanted and made us feel like we were both involved in the birth, and not like it was them doing the birth with me on the table and my husband standing in the corner not knowing what to do.

When I moved I found The Albany midwives, they cared about us, they cared about me and they cared about our baby, and even though I miscarried they were great.

I am going to have another baby, but this time it will have to be in a hospital because I feel I don't have a choice any more. I would like to have my baby at home, but I don't feel that the midwives really are happy with that and if they don't feel safe and happy how can I?

I am really hopeful that all the AIMS campaigns will help the hospital see that women really want and need care like the Albany offered them and that being safe is as much about feeling safe with who is with you as it is all the machines and doctors that are in the hospital but you don't even know their names.

The Albany issues give me hope that things will change, if not for this baby perhaps for the next. Thank you.

Sephora

JOURNALS & BOOKS

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Home Birth – A Practical Guide (4th Edition) by Nicky Wesson
AIMS has replaced Choosing a Home Birth with this fully revised and updated edition. Nicky tells us what the research says, what midwives think, what mothers want, what babies need. Every sentence is packed with interest. It is relevant to everyone who is pregnant, even if you are not planning a home birth. £8.99

The Father's Home Birth Handbook by Leah Hazard.
A fantastic source of evidence-based information, risks and responsibilities, and the challenges and complications of home birth. It gives many reassuring stories from other fathers. A must for fathers-to-be or birth partners. £8.99

Your Birth Rights by Pat Thomas: A practical guide to women's rights, and choices in pregnancy and childbirth £11.50

Am I Allowed? by Beverley Beech: Your rights and options through pregnancy and birth £8.00

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Noticeboard

AIMS 50th Anniversary

Celebrating 50 Years of Campaigning

The AIMS Committee would like to invite you to join us at our celebration lunch to be held at
The London Corinthian Sailing Club, Linden House, Upper Mall, Hammersmith, London, W6 9TA
on 16th October 2010.

There will be Buck's Fizz on arrival followed by a two course buffet lunch, with a toast and 50th Anniversary cake after the meal.

There will also be short talks from well-known and respected speakers.

Tickets are £25, and if you would like to join us please contact ros.light@aims.org.uk Places are limited and will be allocated on a first-come firstserved basis.
We hope you can come and look forward to seeing you on the day

Association of Radical Midwives (ARM)

4th National Conference Building Bridges: Moving Mountains

16th October 2010
Yarnfield Park Training & Conference Centre
Staffordshire

Chaired by Sheena Byrom, and including a session on 'Midwives, mothers and obstetricians: pushing the boundaries' prior to the afternoon 'midwifery question time panel'.

Further information on speakers, workshops and a booking form can be found at www.armconference.co.uk

or email armconference @googlemail.com.

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