DECISION FREE SOLUTIONS

MAKING EXPERTISE MATTER.

ARTICLE | DECISION FREE SOLUTIONS

AUTHOR
Jorn Verweij

DATE
May 10, 2019

REF
A190510

WHY SO MANY WOMEN DON'T GET THE BIRTHING EXPERIENCE THEY HOPE FOR

- A Brief Introduction To Decision Free Birthing Using Mae's Christmas Birthing Story

DECISION FREE SOLUTIONS
KVK 65762355
INFO@DECISIONFREESOLUTIONS.COM

Why so many women don't get the birthing experience they hope for

— *A brief introduction to Decision Free Birthing*

This article provides the solution to the earlier article titled "40 Reasons Mae didn't have the birth she wanted". It includes a brief introduction to the method of Decision Free Birthing (DF Birthing).

Jorn Verweij, Hilversum, May 10, 2019

Content

Why is it so hard for women to have the birthing experience they want for themselves?

Birthing is an entirely physiological process which — provided a stress-free environment — requires no interventions in 95% of all births. But despite the intimacy, the "magic" and its life-altering importance, there is no other life-event so marred by decision making as delivering a baby. The unavoidable outcome of the collective of the often stress-inducing decisions expectant women are confronted with is their disempowerment — preventing them from having the birthing experience they want for themselves.

Although birthing is an entirely physiological process, it is only logical for the expectant women to seek an expert's help in ensuring a safe, non-traumatic, and personal birthing experience. The challenge women encounter in achieving this personal birthing aim is not physiology, it is not complexity, it is not a lack of expert-caregivers either — it is lack of transparency in communication. On one side there is a healthcare system with the tools and expertise to meet medical emergencies, on the other side are expectant women with a personal birthing aim who, in the vast majority of cases, are healthy and carry a healthy baby lying in a favourable position. Yet too many women fail to have the birthing experience they want for themselves.

In the thesis "Birthing outside the system — trauma and autonomy in maternity care"[1], a retrospective survey among 2192 women with a self-reported traumatic childbirth experience is included. In the conclusions it is reported that women attributed the cause of their traumatic birth experience primarily to lack and/or loss of control, issues of communication and practical/emotional support. The women believed that in many cases their trauma could have been reduced or prevented by better communication and support by their caregiver, or if they themselves had asked for more or fewer interventions.

The most obvious reason for women not having the birthing experience they want for themselves is that healthcare systems worldwide do not take a woman's personal birthing aim into account. They don't help expectant women to define one, and they don't ask for one either. A healthcare system that shows no interest in personal birthing aims can't possibly achieve them. Instead, in an idiotic and tragic reversal of logic, the system tends to inundate inexpert soon-to-be-parents with information, and then asks them to write a birth plan for themselves.

Where individual caregivers are generally interested in the wishes and expectations of the expectant mother, the system is first and foremost interested in its own performance. From the beginning of the pregnancy until after delivery numerous choices are made. In absence of a personal aim none of these choices can be substantiated to be of help in achieving this personal aim. From the first referral, to insurer policies, to hospital protocols, to established workflows, to the capacity and availability of the caregivers — there is a broad institutional disregard for the wished-for personal birthing experience. It simply is not taken into account.

In today's healthcare system expectant women encounter three main obstacles in achieving their personal birthing aim:

---

[1] Martine Helene Hollander: Birthing outside the system — trauma and autonomy in maternity care; https://repository.ubn.ru.nl/handle/2066/201204

- The missing role of the personal birthing aim itself.
- The *lack of transparency* in the communication between caregivers and the expectant woman.
- The healthcare system's prevalence of rules, protocols and contracts — which are all made without the woman's personal interests in mind.

The method of Decision Free Birthing sets out change this. Its aim is simple: to empower expectant women to achieve the safe, non-traumatic and personal birthing experience they want for themselves.

What Decision Free Birthing IS and IS NOT about

*DF Birthing is about avoiding unsubstantiated choices. DF Birthing is **NOT** about avoiding all interventions. It is about empowering women to have it their way, be it with or without interventions.*

*DF Birthing is **NOT** against medical interventions. It is against unsubstantiated medical interventions which disempower women. Interventions which are either necessary for medical reasons, or which have been explained to be needed to achieve the woman's personal aim, are empowering women.*

*DF Birthing is **NOT** against providing information to expectant mothers. It is against merely providing information, and then ask soon-to-be-parents to make "informed choices". Informed choices must not be confused with substantiated choices.*

DF Birthing is about "unlocking" the expertise of all caregivers (especially midwifes). DF Birthing emphasises the importance of the role of the 'birthing partner' in reducing stress, and helping the expectant mother to achiever her aim.

What is Decision Free Birthing?

Why there shall be no decision making in birthing

DF Birthing is a method to **empower expectant women to achieve the safe, non-traumatic and personal birthing experience they want for themselves**. DF Birthing is the result of applying the approach of Decision Free Solutions to the "birthing process". The "birthing process" is here defined as the time between the earliest considerations made upon becoming pregnant, and the moment mother and baby begin to develop their routine after the birth itself.

Birthing is a physiological process which takes place all by itself without needing *any* intervention as long as:

- Both mother and baby are healthy (as is determined by prenatal care)
- The baby lies in a favourable position (idem)
- The mother experiences relatively little stress.

This first two conditions are met in approximately 95% of all pregnancies, the latter tends to be a much bigger challenge. That birthing really requires *no interventions* if all three conditions are met

was shown (again) in a dramatic fashion only recently when a comatose woman gave unassisted birth to a healthy baby (link).

Today, for many different reasons, the birthing process — and delivery especially — is associated with both a lot of stress and plenty of interventions. The method of DF Birthing sets out to 1) maximally reduce stress and 2) to limit interventions to those which are either clinically necessary or required to help the expectant woman to achieve her personal birthing aim.

In "Decision Free Birthing" decision-free means that the choices that will be made are substantiated to be in support of the woman to achieve her personal aim. A decision — as follows from the dictionary definition and explained at length here — is an *unsubstantiated choice*. A medical intervention which cannot be explained to help the woman's personal aim is a decision. Any choice made that causes the expectant woman stress and which makes it harder for her to achieve her personal aim is a decision.

As with each decision made — either by or for the mother — the risk increases the personal birthing aim *will not* be achieved, they shall be avoided wherever and whenever possible.

The two parts of DF Birthing

DF Birthing consists out of two parts. The first part consists out of a transparent description of the WHY of the physiological birthing process. Rather than describing HOW the birthing process takes places, it addresses the many ways the entirely physiological process of birthing is aimed at achieving:

- A safe and non-traumatic birthing experience,
- maximally contributing to the well-being of the baby and the mother,
- In both short and long term.

Through the clarification of the *why* of the related physiological events and processes it becomes easier to see their purpose and to accept and also support the various also trying stages of birthing. At the same time is also becomes possible to better assess the effects interventions are likely to have on the birthing process and outcome, helping the expectant mother in determining which interventions she does and which she does not want for herself.

The second part of DF Birthing consists out of four steps and the honouring of five principles (transparency, objectivity, no details, no requirements, no relationship) to ensure the transparent communication between expert caregivers and the expectant woman. This second part will help the expectant mother to achieve her personal birthing aim by providing guidelines to:

1. How to define a personal aim
2. How to to identify the caregiver best able to help her to achieve this aim.
3. Have the identified caregiver make a birth plan which the expectant woman is to approve once it is transparent to her.
4. How the identified caregiver is to assist the expectant woman in the birthing process (to ensure "the birth plan is executed").

Explaining DF Birthing using Mae's Christmas story

DF Birthing provides a solution. But is there *really* a problem? Shouldn't we be simply thankful for our healthcare system? Doesn't everybody just work to achieve what is best for the expectant woman? Are there really so many "unsubstantiated choices" made in the entire process?

The answers to these four questions are yes, yes, no and yes. There are too many women who are grateful, but still had hoped for a very different experience. We should be thankful to our healthcare system for both the prenatal care offered and its ability to safely deliver babies in cases of medical urgency. Unfortunately organisational priorities, protocols, and the absence of a personal birthing aim results in well-meaning caregivers making choices which are *not* in the interest of expectant women. For these same reasons many, many decisions get made. Which brings us to Mae's story.

In December 2018 I wrote a Christmas story and puzzle titled: "40 Reasons Mae didn't have the birth she wanted"[2]. It details Mae's experience from finding out she was pregnant until after delivering her baby. In this "everyday" story a plethora of choices were made which resulted in Mae not achieving her personal aim. This despite the fact that she and her baby were in good health and that the baby had correctly engaged.

The purpose of Mae's story — combined with the "analysis" as provided below — is demonstrate the many, often subtle, ways decisions are made (and stress increased) for the expectant woman. Both the story and the analysis as provided here, are to raise an awareness of how challenging it is for an expectant woman to achieve her personal birthing aim.

Through the story and its analysis it will also become clearer 1) how DF Birthing works in practice and 2) how the way healthcare organisations provide care to expectant women needs to drastically change.

The forty decisions in Mae's Christmas story, annotated

In the table below all choices made in Mae's Christmas story which are *not substantiated* to help Mae achieve her personal birthing aim (i.e. "decisions") are listed and explained. Some of these decisions will be obvious, other subtle and perhaps even appear far-fetched. The only criteria used, however, is whether a choice lacked substantiation in helping Mae, or could potentially cause Mae stress — as both would make it harder for Mae to achieve her personal birthing aim.

[2] https://decisionfreesolutions.com/publication/40-reasons-mae-did-not-have-the-birth-she-wanted/

#Decision	Description
#0	**The personal birthing aim** — In the beginning of Mae's story, Mae finds out she is pregnant and makes an appointment with her physician. Her physician is the gatekeeper of the existing healthcare system. In DF Birthing — in the still to be implemented system set up to empower women — going to the physician is not, logically, the first thing for Mae to do. After all Mae isn't ill, she is pregnant. Decision #0 is what would happen if DF Birthing would be implemented. The first logical step in DF Birthing for someone who is pregnant is to see an expert caregiver who will 1) confirm Mae is pregnant, 2) do a first prenatal check to reassure Mae all is okay, and 3) assist Mae in defining her personal birthing aim. Where Mae will go next — who can best assist her during her pregnancy and during delivery — is to be based on the who, how and where Mae is to achieve her personal birthing aim. At is it, we still do learn what Mae's overarching personal birthing aim is. Mae hoped "to be able to give birth at home, without any interventions. Without somebody telling when or how hard to press. Allowing her to have her baby lie on her chest, skin on skin, immediately after birth. She wanted to give birth "the old way"."
#1	**Making an appointment with your physician** — This will happen more often: what seems nothing less than logical, because this is how the system works, has to be seen from the point of view of how best to achieve Mae's personal birthing aim. Mae is pregnant, *thus* she makes an appointment with her physician. But where the physician may be the best person to see when she is ill, it is not automatically also the best person to see when she is pregnant. Mae is seeing *her* physician because she has to (because she is registered there), and or because she trusts him/her based on provided care. But when it comes to her *pregnancy*, there is no reason to assume her physician is automatically the physician to go to *to get the best possible advice in achieving her personal aim*. She sees her physician based on an existing relationship. This relationship has been established through multiple visits and his ability to help her with her ailments. But helping her achieve her personal birthing aim is not one of them.
#2	**The insurer prevents a home birth based on protocol** — Mae would like to have a home birth. But based on the parameters of "age" and "earlier miscarriages", no midwife willing to assist Mae would be eligible for insurance. The insurer's protocol — which is based on averages or financial calculations, and not on Mae's physical health or personal aims — makes a decision which prevents Mae from even being able to consider having a home birth.

#Decision	Description
#3	**A referral made by the physician** — Mae's physician could, depending on established referral pathways and existing relationships, refer her to a caregiver, a birthing advice agency, a birthing center or a hospital. The physician thus plays a potentially decisive role in determining Mae's future options. All without knowing her personal birthing aim! Thankfully for Mae her physician asked her questions (Mae replying what it is she wants) and thinks along with her. But this is not a given.
#4	**The insurer reimburses based on postal code** — The physician wants to refer Mae to a Birthing Center some distance away from where she lives. Her insurer has a policy in place which bars her from going there simply based on the postal code. Again, what is best for Mae is not a consideration.
#5	**The physician overrules the insurer** — The physician is convinced that Mae's aims are most likely to be achieved in a Birthing Center and ensures the insurer will reimburse her, despite living too far away from the center as determined by postal code. The physician here fails to take into account what Mae's situation is. It turns out that it is exactly because of the distance between the center and her house that she will far from achieve her birthing aim. Should the physician know about this? The physician can hardly be blamed for not foreseeing this scenario. But an expert as introduced in Decision #0 would just be the place where such considerations are taken into account. In the end the physician makes a decision: a choice not substantiated to contribute to Mae achieving her personal birthing aim.
#6	**The husband not wanting to know the sex of the baby** — An essential condition for Mae to achieve her personal birthing aim — in her case avoiding medical interventions — is that she experiences as little stress as possible. Mae should thus be the one to determine whether knowing or not knowing has any effect on stress she might be experiencing. This "decision" is a strong candidate for ridicule, and I'll accept it. But there is also a principle at work here. Again, it are Mae's wishes which are to be considered first. There will come another example later in the story which is similar in nature, but a tad less ridiculous.

#Decision	Description
Note #1	**The midwife drafting a birth plan** — At the Birthing Center Mae meets a midwife who is not only compassionate, but also asks Mae what she wants for herself and her baby. She explains the physiology of birthing, what Mae can expect, what options there are, what the consequences could be etc. etc. The midwife drafts a birth plan based on Mae's birthing aim, a plan which Mae is to consider and approve, but only once she fully understands it. This **does not** happen in practice! This is, instead, *what the method of DF Birthing prescribes to happen.* In practice Mae and her husband would have to make a birth plan. As neither of them are experts in the physiology of birthing, nor in what interventions may have which consequences, this birth plan can only consist out of a collection of decisions. Mae's birth plan, however, is the outcome of a process where decisions are avoided.
#7	**The age-related risk category** — The Birthing Center is connected with a hospital. A hospital protocol decides that Mae's pregnancy falls into a risk category based on Mae's age. This turns out to have devastating consequences for Mae. A protocol is based on averages. Age may a factor in complications. But rather than to let age be a criterium on which to base a string of actions, age — at best — should merely be a criterium to provide extra antenatal care (as Mae also gets). This extra antenatal care is then to ensure that Mae, as an individual, and *despite* of her age, does not have an elevated risk. As is maintained throughout the story, both Mae and her baby are in excellent health. Something protocols completely disregard.
#8	**Attending an educational program on pain medication** — Because Mae falls into a risk category she *has* to follow a program educating her on pain management. This despite the fact that Mae and the baby are healthy, Mae doesn't want pain management, and Mae would like to attend a different program which *would* be in line with her personal birthing aim.
#9	**Insurer covers only one educational program** — Mae was forced by the hospital to follow a program she had no need for, and because of a restriction by her insurer missed out on a program which was in line with her achieving her birthing aim. Must insurers blindly reimburse educational programs? No. But insurers would help expectant mothers by avoiding decision making and taking personal birthing aims in consideration.

#Decision	Description
#10	**Mae taking her husband's concerns into consideration** — Mae decided to not take the program which was aimed at reducing stress during delivery — the very thing she would benefit of most. Even though Mae was sure her husband would not object to it, she did not want him to worry about the cost. Mae made a choice which could even be substantiated to make it *less* likely for her to achieve her personal aim. The story hints at financial stress. Perhaps the program was prohibitively expensive, and then it would simply not be a choice (and thus not a decision). The larger point to be made is that what is in the best interest of the expectant women is be taken into account *first* when making choices.
#11	**Protocol for when to deliver at the Birthing Center** — Just another example of a protocol. Mae has to be 37 weeks pregnant before she is allowed to deliver at the Birthing Center. Not something that is based on health or on expected complications, but on a number. And without taking Mae's birthing aim into account.
#12	**Contract determines whether midwife can assist** — The midwife who had brought Mae almost to tears with her compassion, who understood Mae's aim and who had drafted the birth plan for her, would not be able to assist Mae for having made too many hours as allowed by her contract. The contract makes a decision without taking Mae's aim into account.
#13	**Reduced capacity around Christmas** — Babies don't take holidays into account. The reduced capacity is merely an organisational choice. It means that the likelihood that the rooms in the Birthing Center would be occupied is dramatically increased. And so is the likelihood that Mae would have to deliver in the hospital.
Note #2	**Joe's mild night blindness** — It is here that we find that the physician's referral to the distant Birthing Center (overruling the insurance policy in doing so) is backfiring. As Mae is to deliver in the darkest time of the year (Christmas time), Joe has night blindness, and a taxi is too expensive, the distance to the Birthing Center is posing real problems and may lead to difficulties. And it does.
#14	**Joe's early leaving** — Joe has a mild form of night blindness, which makes him nervous. Although it is too early to go the Birthing Center, and Joe was going to be fine as long as he would drive slowly, he decides for them to go to the Birthing Center early. This is not in Mae's best interest.
#15	**Appointing of another midwife** — As Mae's midwife isn't working (see #12), another midwife is appointed to her. This form of "resource scheduling" is a decision as no consideration is made whether the midwife has the experience and expertise required to achieve Mae's personal birthing aim.

#Decision	Description
#16	**Midwife informing them of the sex of their baby** — Following the prenatal examination the new midwife refers to the baby with 'he'. She relates the sex of the baby despite the fact they (Joe) requested not to know. This news may well have caused stress, which is the last thing Mae needs right now.
#17	**Mae can't wait in the room in the Birthing Center** — Mae can't wait in the delivery room in the Birthing Center because she is not dilated enough. This is a protocol taking a decision. There is no obvious reason as to why she can't wait in the room she hopes to give birth in. It would be more relaxing than waiting in the hospital. If the room is needed for another woman she can simply leave (which is not "a hassle"). As we will learn later, this room will remain empty.
#18	**Midwife organising stay in the hospital** — Mae has to go home as she will not be delivering for a while (#17). The midwife, employed by the hospital, knows of a way for them to wait in the hospital. This may seem practical, but it literally moves Mae into a healthcare system she is trying to avoid. The midwife proposes a solution which does not help Mae to achieve her personal aim.
#19	**Mae receives priority status** — Based on two somewhat elevated blood pressure readings (the second of which took place while she had a surge and might even be a "false reading") she qualifies for a "priority status". Mae and the baby, however, are still doing great, and there is no need for her to get this status. This status triggers yet more protocols.
#20	**Because of priority status Mae is offered a hospital bed** — The "priority status" — which the nurse gives her even though she knows Mae doesn't actually qualify — triggers a protocol which means Mae has to deliver in the hospital.
#21	**Midwife assumes she can overrule protocol** — An assumption is, by definition, a decision also: you are not certain it is correct. An assumption does not by necessity contribute to achieving the aim. The nurse assumes she can give Mae "priority status" and still get her back into the Birthing Center.
#22	**Joe indicates his preferred choice** — When the nurse explains that she can go and wait in the hospital Mae isn't listening. In trying to get Mae's attention Joe's excitement is a strong indicator of what he wants Mae to do. Joe doesn't want to drive, and so he is nudging Mae into accepting the midwife's offer. Joe is not contributing to Mae achieving her aim here.
#23	**Mae brought to delivery room instead of maternity ward** — Upon the transfer to the hospital, where she was, according to protocol, to wait in a private room at the maternity ward, a nurse brings her to a delivery room instead. We don't know why this decision was made. We do know it is not what Mae wants.

#Decision	Description
#24	**Joe doesn't inquire after Mae's needs** — Mae is very tired and not where she wants to be. Doing relaxation exercises is proving more difficult than she had anticipated. Joe is preoccupied with other things and fails to inquire what she needs. He could help her do the exercises. *Not* inquiring what his wife might need from him is a decision also.
#25	**Joe tells Mae it is a boy** — As it happens Mae already knows. Sharing this information with her at this moment might easily have caused her more stress. Her need to feel as relaxed as possible is not on his mind.
#26	**Delivery room is bright and chilly** — Brightness and cold temperatures make for good working conditions for the hospital staff, but impede the physiological birthing process. It also makes it harder for Mae to do visualisations to relax. An organisational choice, a decision from Mae's perspective.
#27	**Constant monitoring** — At this point the "priority status" protocol kicks in and a series of decisions are made which make it still more impossible for Mae to achieve her aim. Because of the constant monitoring and the cannula it becomes impossible for Mae to leave the bed. Doing relaxation exercises — which would help Mae get closer to her aim — becomes all the more challenging.
#28	**Nurse rotation** — Every thirty minutes one of the nurses comes by to measure dilation. This may be practical from an organisational point of view, but the constant coming and going of different people only causes Mae additional stress.
#29	**Keeping Mae in the hospital** — At the Birthing Center both rooms are available and Mae can, in principle, return when she is 6 cm dilated (a requirement is a decision also). But is the returning of a "priority status" patient to the Birthing Center even "allowed"? Whether it is allowed or not does not become clear, but this would, of course, be the one opportunity for Mae to have a chance of achieving her personal birthing aim. To keep her in the hospital not even knowing whether it is necessary is a decision in itself.
#30	**Access to the legal department** — The legal department can resolve the issue that is raised. But to always have access to legal opinion to quickly resolve issues surrounding protocols and birthing is not something that the organisation provides. It is left to the personnel to try and get in touch with someone. To not provide this access is an organisational choice, and from Mae's perspective a decision.

#Decision	Description
#31	**No drinking and eating, just in case** — Another protocol issue. Just in case Mae ends up needing an emergency cesarean she is not allowed to eat or drink. It is actually why she has a drip: to keep her hydrated without having to drink. To stay sober may be a somewhat substantiated medical intervention to reduce the — already very small — risk of aspiration in case of a scheduled surgery. But the expectant mother is to feel good and as stress free as possible for delivery. The mere *idea* of a cesarean is causing Mae stress. Also, there is no evidence of any complications during emergency C-sections caused by the mother (modestly) drinking and eating.
#32	**The obstetrician not wanting to wait any longer** — The birth has stalled. This isn't unusual and birth might begin to progress by itself (which might be helped if Mae could relax). For no substantiated clinical reason — as Mae and the baby were still doing well — the obstetrician decides to "help the birthing process forward". Not what Mae wants.
#33	**The obstetrician strongly advises an epidural** — One medical intervention (administering of Pitocin, causing more frequent and intense contractions) is likely to lead to the next (an epidural to manage these strong surges better). For this very reason, in light of Mae's personal birthing aim, the first medical intervention is a decision. The obstetrician "strongly" advising Mae to have the epidural (to "make everything easier") means he is putting pressure on Mae to make yet another decision.
#34	**Letting Mae decide the medication dose** — The pain management nurse shares a lot of details with Mae and then asks her to make a choice. As Mae is both exhausted and no expert when it comes to the dose of pain medication, the nurse forces Mae into making a decision.
#35	**The obstetrician making the argument for a C-section** — Even though the medication is working, and merely because an operating room is available and there is still time before the next personnel shift takes place, the obstetrician argues for Mae to have a C-section. This is not what Mae needs, it is not what she wants, and it causes her still more stress.
#36	**The personnel shift** — The coordinated personnel shift makes perfect sense from an organisational point of view. But every shift comes with challenges of information transfer. It is this risk which, at least in part, triggers the obstetrician to make his suggestion for a medically unneeded cesarean. Of course *any shift* of personnel is a potential cause of stress for the expectant woman, and something which does not contribute to her achieving her personal aim.
#37	**An episiotomy to speed things up** — There is no clinical reason for the episiotomy. "Speeding things up" is not a personal birthing aim.

#Decision	Description
#38	**The obstetrician telling Mae to push** — In an unmedicated birth the natural expulsion reflex will deliver the baby. There generally is no need for coaching as the woman will simply start to push when the urge arrives. After an epidural the coaching may help, as this urge may not be felt the same way. Mae didn't want any coaching, and it remains unclear whether the coaching was or was not necessary here. It is, in any case, what the obstetrician decided to do.
#39	**The clamping of the cord** — Directly after delivery the cord usually still pulses and may transport a significant volume of blood from the placenta to the baby. There is no medical reason to clamp the cord. It is not what Mae wanted.
#40	**The immediate check-up** — In absence of any indication telling observant caregivers otherwise, a baby doesn't need to be taken away upon delivery for an immediate check-up (leaving Mae alone with the obstetrician still doing his work). Often this is simply part of a protocol. It is not what Mae wanted.

A Decision Free Birth in practice

To get an idea of what an (attempt at a) Decision Free Birth looks like in practice, you can read this case description.

For more information visit this page (our website), or contact me at jorn@decisionfreesolutions.com

DFS CONTACT INFORMATION

+31 6 538 64545

info@decisionfreesolutions.com

linkedin.com/company/decisionfreesolutions

@decision_free

Search for: Decision Free Solutions

Decision Free Solutions
Potgieterlaan 9
1215 AH, Hilversum
The Netherlands
+31 6 538 64545

KvK 65762355
BTW NL 141648272B01
NL60 TRIO 0390480509

info@decisionfreesolutions.com
www.decisionfreesolutions.com