PAIN RELIEF IN LABOUR - WOMEN'S PERSPECTIVES

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Childbirth for the majority of women is a normal physiological event. Yet, today our society's perception of childbirth is that it is also an unbearably painful and often dangerous experience. Such perceptions have a long history. The Bible states *"I will greatly multiply thy sorrow and the conception - in sorrow thou shalt bring forth children."* (Genesis 3:16).

Normal delivery is defined medically as any birth that achieved vaginally without the use of ventouse or vacuum extraction, yet, that is not an adequate explanation. To the informed consumer groups a normal birth is a vaginal birth, without the use of ventouse or forceps, which follows a physiologically normal labour. The two cannot be separated and, therefore, women who have their labours induced, or accelerated, have epidural anaesthesia, electronic fetal monitoring and episiotomies cannot be considered to have had a normal birth. The normality has been perverted by hospital practice. Yet the images and information presented to the mother through the media and by many members of the profession are that these births are *"normal".*

The result of this propaganda is that hospital staff have lost sight of what normality is (because they have re-defined it to fit in with their largely unnecessary interventions) and the women themselves have a distorted view of childbirth. Indeed, a childbirth campaigner in Newcastle commented that the obstetricians in that city had successfully destroyed the confidence in their ability to give birth normally of two generations of women.

That confidence has been destroyed by the medical and midwifery professions concentrating on *"what can go wrong".* That attitude is then re-inforced by the *"just in-case syndrome".* That syndrome requires the profession to intervene at the earliest possible moment to avoid *"something going wrong".*

Women are brought into hospital to have their babies not because hospitals are the safest places to have babies (because they are not) (1) but in order to justify the *"just in-case"* syndrome, on the grounds that the staff will have all the

equipment available to take the appropriate action. The difficulty with this scenario is that sometimes hospitals do not have the staff on hand to intervene immediately a problem arises.

Women are left on their own for long periods of time, and even if the machinery tells the staff that something is going wrong they often don't take any notice of it anyway (2). Furthermore, having brought women into hospitals to have their babies the pressure is then on for the women to deliver those babies as soon as possible.

A woman who has a *"stop/go"* labour is a nuisance who is cluttering up the ward and using up staff time, how much better it is to make sure that the babies are delivered from Monday to Friday and from 9.00am to 6.00pm. It may be that obstetricians do not organise their schedules to suit their golf practice, but they most certainly organise their schedules to fit in with their private practice and the staffing needs of the labour ward. It is a national disgrace that the control of women's birth experiences is not dictated by the needs of the women and their babies but by the staffing levels in the hospitals.

Today, in Britain, women experience labour as patients and it is significant that labours are *"managed"* and *"conducted".* This interesting terminology implies a passive patient. Midwives have, in general, lost their role as *"with women"* and have been forced to take on the role of obstetric nurses and managers. The women, meanwhile, are now required to take a passive role in the business of delivering the baby, and *"delivering the baby"* not *"giving birth"* is the significant phrase.

All *"good"* patients are, therefore, required to be passive, do as they are told and be quiet. Women who make a noise during their labour are generally considered to have an adverse effect on everyone. Those women who make too much noise are often given pethidine, not because pethidine does anything for painful labours but it is very effective indeed in silencing the noisy labouring woman. As one woman remarked to AIMS *"Pethidine did nothing for the pain but I felt that it turned me into a good patient."*

For many women admission to hospital for the birth of their first child may be the very first occasion that they have set foot inside a hospital. They are being admitted to a strange environment to take a central role in a process of which they have no experience at all.

The majority of British women have very little contact with small babies and very few indeed will have seen a labour and the birth of a baby before their own experience. They are, therefore, very dependent upon those who attend them, and above all they need large doses of tender loving care and a constant supportive companion. What they get, in general, is a companion who is even

more ignorant than they are of the birth i.e. their partners, and a professional attendant who is only occasionally around.

Mavis Kirkham in her excellent study on giving information to patients revealed how patients' questions are misinterpreted by midwives(3). One mother rang the bell to find out how she was progressing. Her question was misinterpreted as distress and she was given an injection. The mother did not learn how she was progressing until she delivered the baby.

Ms Kirkham's study showed the enormous need for information and how little information the mothers are actually given. One mother commented *"I don't think pain is half so bad if you know how long it's for."* Uncertainty breeds anxiety and the structure of maternity care in this country tends to encourage anxiety. It is important to realise that communication involves much more than merely informing the woman, or her partner, or giving them information.

Klein in his study (4) of low-risk women delivered in GP and Obstetric units found that women admitted to the GP unit suffered less inductions, fewer epidurals, had less pethidine, fewer forceps deliveries, less fetal distress and had less breathing difficulties with the babies after the birth.

When a women is admitted to hospital she is shown a bed, and one of the first reactions she has is to get into it. Having got into it, she then has little to do except lie there and think about what is happening to her and worry about what might happen to her. It is this process that causes the woman the first ripples of anxiety, although she may be unaware of it. It is recognised that labour stops following the admission of many women to hospital, in some hospitals they now encourage the women to walk about, but there are many hospital that do not. They put up a drip instead.

The first pangs of anxiety caused by the admission to hospital are now compounded by the isolation, which is further compounded by the oxytocin drip. Is it then any wonder that women start screaming for pain relief?

The standard response to pain relief in British hospitals is the administration of pethidine or epidural anaesthesia. How many hospitals offer the women a warm bath, or even better how many hospitals have organised themselves so that the woman has a supportive lay companion to help her?

It cost hundreds and thousands of pounds for a study to be conducted in South America (5) which showed that a very effective method of shortening labour and reducing the need for pain relief was achieved by organising a supportive lay companion. This study has, in the main, been overlooked in Britain. It is much more fun to find out whether Meptid is a more effective pain reliever than Pethidine or whether epidural anaesthesia is better than using morphine, or any one of the fifty-seven different varieties of drug comparisons. None of these

drug trials ever compare the value of a particular drug with non-invasive means of helping with pain relief.

Studd has remarked on how grand multips (women who have given birth to five or more children) have commented that getting into a warm bath is the best method of pain relief they have ever tried, yet who is carrying out a study to find out how effective it is? Enkin showed, in a randomised controlled trial of Leboyer birth (6), that the assurance that the baby would be treated gently and delivered in a quiet environment was sufficient to significantly shorten the labours.

Because childbirth is projected as a terribly painful event, women with no experience of childbirth are now queuing up to book their epidurals. They feel that to have an epidural and be able to sit and do The Times crossword is a positive advantage. Undoubtedly, there are women who have had that experience and are delighted with it and only too keen to produce their statutory 2.4 children and rush back to their careers, however, many of them find that giving birth to a baby in a totally painless and distanced fashion is less than satisfactory. It should be clearly understood that it is not that women wish to endure pain, it is that women wish to feel that they have *"given birth"* and many women who have been delivered while doing the Times Crossword subsequently feel that they did not really experience childbirth at all.

Epidural anaesthesia is a wonderful technique for a woman who has had a long, difficult and exhausting labour, but one must question why it is that our society so terrifies women that they are willing to book a procedure that has the potential of removing them completely from the experience of giving birth rather than face what they believe to be a horrible ordeal. Many of them have never given birth before and, therefore, must be basing their views on what they have seen in the media and heard from their friends and the professionals who attend them.

The enthusiasts of epidurals and other pain killing drugs are often incapable of understanding why women should wish to *"give birth naturally",* and perceive natural childbirth in hospital terms. They look upon women who want a natural birth as self-centred mosochistic perverts, who are only interested in their own ego trip and not interested in the well-being of the baby.

In the enthusiasm to promote epidural anaesthesia the enthusiasts often overstate their case. Andrew Doughty in the Duncan Flockhart information tape on epidural anaesthesia, which AIMS, incidentally, had withdrawn from the market because of the inaccurate information it contained, and its breach of the ABPI Code of Standards, referred to pain in childbirth as *"... the first pain and the constant pain throughout labour."* Is it any wonder that women are fearful? They conveniently forget that the majority of drugs used in childbirth have adverse effects on both the mother and the baby, and it is because of these

adverse effects that women are beginning to demand a return to midwifery ideals.

No-one would want to see women in labour in a great deal of pain denied the use of a means of delivery without excessive pain. Unfortunately, in the majority of British hospitals the only method of pain relief available is the drugs' cabinet.

It is a tragedy that in order to experience a normal birth British women first have to experience an abnormal one (i.e. a technological hospital delivery). Only then, it seems, are they allowed to have a home or GP unit birth (providing, of course, that the hospital has not perverted the first birth to such an extent that they are no longer considered low risk).

The experience of women in British hospitals has resulted in large numbers of women being fearful of giving birth, which only rarely is presented as a joyful and fulfilling experience. There have been many examples of births like that but very rarely indeed have those births taken place in a hospital.

Britain has the highest levels of obstetric interventions in the whole of Western Europe and they also have one of the highest levels of mortality and mobidity. The WHO report *"Having a Baby in Europe"* published this week states that *"It is forgotten that most pregnant women in Europe could have a completely uncomplicated pregnancy and birth, and a healthy newborn baby without any medical intervention. The growth of alternative birth services testifies to the sense of dissatisfaction felt in many European countries to the medicalization of birth by the official health system"* (7).

Parents are demanding a return to natural childbirth methods and a re-instatement of the skills and role of the midwives. The response from the medical and midwifery professions has been very disappointing. Some brave individuals are trying to structure the care in their areas to cater for these demands. They are brave because every single one of them is under threat. From Wendy Savage, who has been suspended, to Caroline Flint whose *"Know Your Midwife"* project was abandoned at the earliest possible moment.

The questions that should be addressed are not the benefits and risks of pain relief in childbirth, but why is it that British hospitals have provided a standard of care that necessitates the use of powerful painkilling drugs in the majority of labours; and why is it that those non-invasive interventions and patterns of care which have been shown to be better, and are available, are either ignored or killed off as soon as possible?

By focusing pain relief in childbirth in general the impression is given that the issue is being addressed when in reality the real issue is not even being considered.

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