



Things are changing...

By Jane Wright

[AIMS Journal 2003, Vol 15, No 4](#)

AIMS has been in the forefront of campaigning to improve maternity care for the last 43 years and, for those who've been involved for a long time, it is sometimes useful to look back at what care was like many years ago, and see just how many changes have resulted from constant consumer pressure. Jane Wright considers the changes that have taken place in Northern Ireland

The reason I joined AIMS in the first place was because of the horrific treatment of women that I saw while a student nurse in 1982. I have not forgotten how women were herded through a booking clinic, where they were told to strip and get up onto a table, where they underwent an internal examination, smear test and breast examination under the eyes of whatever students were around, without the slightest regard for these women's dignity or embarrassment (permission was never asked). One obstetrician did not even give eye contact to the woman and barely spoke to her except to give orders. I felt abused just watching the examinations. I can't begin to imagine how the women involved felt.

That particular obstetrician played rugby on weekends, and perhaps he didn't like having his weekends interrupted because all women were induced at 38 weeks. He refused to accept the women's dates (perhaps because he suspected that some women lied about their dates to avoid the inductions) and, instead, induced women based on their scan dates.

All the women he considered 'due' were induced on Tuesdays or Thursdays. This meant that the two labour rooms had to be shared by two women each, and women were sometimes labouring in the corridors. There were not even screens between the women.

The routine was this. Women were brought in the day before, given an enema and a pubic shave. (This was the same routine for emergency admissions except they were told to shower, even if they had had a shower immediately before coming into hospital.) The following morning they were taken round to the labour suite, where an ergometrine infusion was commenced and the membranes ruptured. One of the obstetricians did this under sterile conditions using an amnio hook, in a delivery room; another obstetrician would carry out an internal examination in the labour rooms, under the eyes of the other poor woman sharing the room (remember, no screens), and rupture the membranes with his fingernails. He never explained what he was going to do or, indeed, what he had done. He barely communicated with his patient at all. Pain relief was two ampoules of pethidine and two of Pethilorfan (known as the 'two and two'), which made the women sick and disorientated, but didn't remove the pain.

Women who were for caesarean section were also catheterised prior to theatre, which was very stressful and embarrassing, and at a time when they were already very frightened. One of the consultants insisted on all women being catheterised for just samples of urine. There seemed to be no concern over the risks and discomfort this caused.

Once a woman was in labour, she was largely confined to bed in her room. Again, internal examinations and catheterisations were carried out without any effort for privacy other than to ask the woman's partner (and the partners of her 'room-mate') to leave the room.

I think some midwives did try to give support and encouragement to labouring women, but most of them saw nothing amiss in this treatment regime. Anyone who raised concerns would have found it difficult, so I think many chose to become token torturers and not buck the system.

Every woman I saw delivered had an episiotomy. Every woman was delivered in the lithotomy position with her legs strapped in stirrups. Every woman was given Syntometrine on the birth of the baby's shoulder. All cords were cut immediately on the birth of the child. Suturing of the episiotomy was carried out by whichever house officer was around - and some were so inexperienced, I wouldn't have let them sew up a chicken, but that didn't preclude their having a go at a woman's perineum. All babies were taken to the nursery where I had the feeling bottlefeeding was much more convenient for the nursery midwives.

There was no such thing as home births or even Domino deliveries. Water births had not been heard of, and patient choice was only for the consultants' private patients and extended only as far as choosing the consultant.

Three years after I left, I heard that some GPs complained about the induction of women at 38 weeks on Tuesdays and Thursdays. I asked the Chief Executive what had changed. He told me they now induced on all weekdays-still at 38 weeks, you understand, "but it looks better".

Twenty-one years later, I still have nightmares about what I saw in the four weeks over Christmas-but much has changed. No one would now tolerate forced induction routinely at 38 weeks. Privacy and respect for women's dignity has dramatically improved. Routine showers, shaves and enemas have

ceased. Pain relief has many more options, and I don't know of anywhere that still uses the 'two and two'. Water births are becoming common practice, and home births, while still rare, are becoming much more widely available. Midwives are becoming more confident at challenging questionable practices and care has become much more individualised. I think Direct Entry Midwifery courses will help this process. I'm not for a moment saying that we don't have a long way to go, or that there aren't still some black spots around, but I do feel a growing sense of optimism.

I think, increasingly, women themselves reject the Doctor-knows-best approach and, for better or worse, many women no longer trust the medical staff with the blind faith that TV's Dr Finlay instilled in us. My mother would have done bunny hops around the hospital with a pineapple on her head if 'The Doctor' had told her to (and then given him a bottle of whisky 'for his trouble'); young women today will not.

Twenty years ago, research was thin on the ground and considered an irrelevant nuisance by some practitioners. It is a very foolish professional, nowadays, who wantonly fails to practise on the basis of hard evidence. I am delighted that medical professionals are being increasingly asked to defend their practices to women's groups, consumer groups and their own professional groups. The growing number of CREST guidelines (whose guidelines have a role similar to that of NICE in England) make it increasingly hard for any health professional to say: "Well, this is the way I do it...", and remain unchallenged.

I look forward to seeing what will have changed in another 20 years.