AIMS For a better birth...

Research Roundup

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By Jean Robinson

What Do Doulas Do?

A number of randomized studies have shown that labour and birth outcomes are improved when women have a "doula" - a supportive female birth companion. The presence of a doula can improve bonding, decrease postnatal depression, reduce length of labour, and improve breastfeeding. In some studies the doulas had received training, in others they were simply women from the community.

Now from Mexico City we have a valuable report of in-depth interviews with women to find out what difference the presence of a trained doula made to first time mothers. 16 women were interviewed - half had had a doula and half did not. They had given birth in a hospital where there was a tendency to induce or medically intervene in labour, to use epidurals and episiotomies, and which had a 20% caesarean section rate. What is more women are not allowed to have their partner or a companion in labour.

Women showed a passive attitude towards the hospital system, and adapted as well as they could. They observed that others who made a fuss got even less attention, so they quickly learned to keep quiet. When interviewed, the group who had had a doula were *better able to mention aspects of care they had not liked.*

All the women complained of the lack of information, but those with a doula had *more easily been able to ask questions* of staff even when they were busy. Even when they were not able to ask questions, the women were able to cope with doubts better by talking to the doula.

There was an interesting contrast on vaginal examinations. Women with a doula said how painful and shaming they had found vaginal examinations (VEs) - they would have liked fewer and more careful examinations. Those without a doula did not object to VEs so much because *it was one of the few times they got attention.* There was shame and pain - but it was the only time they got information on progress.

For women who had a caesarean section, those who had a doula were better able to understand the

reason for it and were *less likely to feel frightened and guilty*.

Almost all women found labour painful, but those with a doula *found pain more bearable.* They also had a better picture of *how labour was progressing.*

Women who had a doula tended to *have a positive attitudes towards themselves* after the birth. They had been aware of what was happening and could think of labour as a process; the pain made sense. But most of the women in the control group were left with the impression that it was the doctors who had done all the work - delivery was just a series of interventions.

What women with a doula appreciate most was the continuing presence of a caring person. The women without a doula would have liked a companion - their mother or husband, "to have some support, to feel someone's affection, to feel I was important." The authors say their study supports the idea that women in childbirth, especially a first-time birth, "have a deep need for company, empathy and concrete assistance."

AIMS Comment

Randomized studies can only show us crude outcome measures. We also need in- depth qualitative studies like this to show us what women think. What struck me most about this study was the appalling quality of care women were getting in this hospital with its medical rather than midwifery ethos. Women were not allowed companions, they were not given information, they were hardly spoken to and doctors were authoritarian. The emotional damage to women must be horrendous and the joy and achievement of birth are lost. No wonder doulas have been shown to be so effective. They provide a small dose of prophylactic emotional antibiotic in a setting which is psychologically toxic.

Women were interviewed "some hours after delivery". We know, of course, from other studies that interviews after women have left hospital allow them to be more critical of the care they had. The authors admit that doulas "offset the depersonalization that is characteristic of these types of institutions". But is it possible that doula provision, valuable as it is, mutes the drive to reform both the institution and the medical profession? The doulas are helping women to hold on to some of the self esteem which the maternity hospital attacks. Why are we pulling bodies out of the water instead of draining the swamp?

Yes, doulas are good. But any hospital that needs doulas this badly should be ashamed of itself. In a good hospital, with one-to-one midwifery care, and the presence of companions of the woman's choice, how much difference does a doula make then?

Reference

- Campero, L et al. "Alone I wouldn't have known what to do" - A qualitative study on social support during labour and delivery in Mexico Soc Sci Med, 1998; 47: 395-403

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Scans Don't Help Growth Retarded Babies

A study from Germany compared babies whose growth-retardation was diagnosed by ultrasound in the womb, with those whose smaller growth was not detected until after birth.

One of the promises held out by antenatal scanning is that obstetricians will be able to identify the baby with problems and do something to help it. One of the purposes of screening is to identify unborn babies suffering from intrauterine growth retardation (IUGR) - not as big as they should be for their dates.

German maternity care guidelines specify that every mother should have two scans, although the current study showed an average of 4.7 scans per woman. This study comes from Wiesbaden hospital, where women had care from 175 doctors and there is a 20% caesarean rate. Out of 2378 pregnancies, only 58 of 183 growth retarded babies were diagnosed before birth. 45 fetuses were wrongly diagnosed as being growth retarded when they were not. Only 28 of the 72 severely grow- retarded babies were detected before birth.

The babies diagnosed as small were much more likely to be delivered by caesarean - 44.3% compared with 17.4% for babies who were not small for dates. If a baby actually had IUGR, the section rate varied hugely according to whether it was diagnosed before birth (74.1% sectioned) or not (30.4%).

So what difference did diagnosis make to the outcome for the baby? Pre-term delivery was 5 times more frequent in those whose IUGR was diagnosed before birth than those who were not. They average diagnosed pregnancy was 2.3 weeks shorter than the undiagnosed one. The admission rate to intensive care was 3 times higher for the diagnosed babies.

There was 1 perinatal death in the 58 diagnosed babies and 1 in the 125 undiagnosed group. This is not a statistically significant difference and could arise by chance. Average Apgar scores were lower in the diagnosed group, but again the difference was not statistically significant.

AIMS Comment

This important study, from Heidelberg University, shows a huge difference between percentage of IUGR babies detected in everyday care and real life, and the much higher percentage shown in published studies elsewhere. We think this is true for many aspects of medical care, where research studies show promising results which are not replicated outside centres of excellence (and maybe not even inside

them). It also provides further evidence that the scans German women are guaranteed under their health care plan are not benefiting their babies. Incidentally doctors at the hospital do not use simple tape measuring of the size of the tummy (symphisis-fundus height) which has shown to be as effective as good quality ultrasound in detecting growth retardation.

Reference

- Jahn A et al, Routine screening for intrauterine growth retardation in Germany: low sensitivity and questionable benefit for diagnosed cases; Acta Ob Gyn Scand 1998; 77: 643-89

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Ultrasound Failure in Norway

In a new study from Oslo, pediatric surgeons looked at how many babies born with serious defects had been diagnosed by antenatal scans, and whether the early diagnosis made any difference to the outcome. Women in Norway have a scan at 17-18 weeks done by trained midwives, who refer to obstetricians if an abnormality is suspected.

In 19 months 36 babies were referred, from a population of 2.5 million. They had diaphragmatic hernias, abdominal wall defects, bladder exstrophy or meningomyelocele. Only 13 of the 36 defects had been detected before birth (36%). Mothers had actually had an average of 5 scans (from 1 to 14). Those whose abnormality was detected had had an average of 7.

3 out of the 13 babies diagnosed antenatally died. There was 1 death in the 23 undiagnosed. All 13 babies with antenatal diagnosis were delivered by caesarean. 19 of the 23 undiagnosed babies had an uncomplicated vaginal delivery. The diagnosed babies had lower birth weight, and two weeks shorter gestation. Although the babies with pre-diagnosed abdominal wall defects got surgery more quickly (4 hours versus 13 hours) the outcomes were the same in both groups.

The authors conclude that they had found no benefits of ultrasound antenatal diagnosis in either reduced mortality or morbidity, but they point out that it could be that the most seriously affected are the ones most likely to be diagnosed. Since they only looked at live babies which reached them, they did not know how many other abnormal babies might have been diagnosed and aborted.

AIMS Comment

Yet another study showing that detection rates for serious abnormalities can be low - and much lower than mothers realise - and that early diagnosis may not benefit the baby at all.

Reference

- Skari, H et al, Consequences of prenatal ultrasound diagnosis: a preliminary report on neonates with congenital malformations Acta Ob Gyn Scand 1998; l77: 635-42

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Caesareans Increase Future Risks

Placenta accreta is a condition where chorionic villi from the placenta have grown down into the muscles of the uterus and there is no clear separation between the placenta and the wall of the uterus. This means that the placenta cannot be easily removed without risk of torrential haemorrhage, which can kill the mother, or perhaps her life can only be saved by an emergency hysterectomy.

The condition occurs more often when there is placenta praevia (i.e. the placenta is placed low down in the womb where it may partially or totally obstruct the baby's entrance to the birth canal)

A recent study from Saudi Arabia looked at risk factors. In 23,000 deliveries 100 women had placenta praevia and 12 of them had placenta praevia accreta. A woman's age or the number of children she had made no difference to the risk.

The risk went up when the woman had had a previous caesarean - and the more caesareans, the higher the risk. 75% of the accreta cases had had a caesarean. The percentage of placenta praevias which were embedded increased from 4.1% in women with no previous section, to 60% in patients who had three or more caesars. One of the patients died from a massive haemorrhage - she had had two previous sections.

AIMS Comment

This is the latest in a number of studies which show that caesarean section increases the risk of both placenta praevia and placenta accreta in subsequent pregnancies. As our caesarean rate rises, the number of women at risk of massive haemorrhage, emergency hysterectomies, and maternal death, increases too.

Reference

- Zaki, M, et al, Risk factors and morbidity in patients with placenta previa accreta compared to

placenta previa non-accreta, Acta Ob Gyn Scand, 1998; 77: 391-4.

- See also Caesareans cause placenta praevia and accreta from the Winter 1999/2000 AIMS Journal.

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