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# Women as Obstetric Fashion Victims

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*Jane Wright highlights her paper delivered to the NCT AGM and conference, 13th October 2007, Belfast.*

On Monday 3rd September a UTV programme covered the opening of the new maternity unit at the Ulster Hospital. It depicted the freshly painted birthing suites with their seven birthing pools and other aids designed to assist in normal labour. Was I the only person who was disappointed, then, when the first birth in the new unit was by caesarean section? I hope the manner of this first birth is not prophetic.

In 1985 the WHO1 stated that no geographic area should have a caesarean section rate of more than 10-15%. Despite this, caesarean rates have climbed from less than 5% in 1965 to rates of 80% in present day Brazil2. Sixteen years ago, when I joined AIMS, the average caesarean rate in NI was 13%. The Mater and Ards hospitals had the lowest rates at 9%, and the Royal had a rate of 21%. Today, in Northern Ireland, over a quarter of all bir ths are by caesarean section and the rates approach 1/3 in the Royal Jubilee and Craigavon Area Hospitals. Indeed I was told by a nurse from Craigavon, recently, that obstetricians now operate every day 'to meet the demand'. There are no valid medical reasons to justify this rise. Women today are healthier, taller, have fewer pregnancies and more access to health care than ever before. Rationally, there should be fewer caesarean sections than at any time in history.

This appaling state of affairs is not easy to explain. Reasons given for the rise include, patient choice (although I've never met a woman who would want a caesarean once they understood the risks), litigation (although litigation is still comparatively rare in NI and usually unsuccessful) and convenience for medical staff. I suggest one further cause, an element of fashion about the procedure.

Thirty years ago shaving and enemas were de rigueur. Sixteen years ago episiotomy was fashionable and we had maternity units, for example Craigavon Area Hospital, which had a 41% episiotomy rate. In other units it was described on audits as 'routine'. Induction was also fashionable, with the Erne, in Enniskillen, inducing all women (on Tuesdays and Thursdays) at 38 weeks gestation. In Adair House, in Ards, the rate was 66%. Induction does not have quite the same cachet is once did and episiotomy is no longer in vogue but caesarean sections are currently quite the very thing.

Unfortunately, like most meddlesome medical practices it has risks and disadvantages for all involved. A caesarean section costs twice as much as a vaginal delivery wasting thousands of pounds of NHS money every year. Midwives have lost many of their most precious skills. It is increasingly rare to find midwives who are confident in breech vaginal birth, external cephalic version, twin births or vaginal birth after section (VBAC). The tendency to label anything but the most straightforward pregnancy as 'high risk' of

course leads to increased levels of caesareans. Yet caesareans are far from the safest option for many births.

A mother is 2 to 7 times more likely to die from caesarean section than from vaginal delivery3. Problems associated with caesarean section are: infection, haemorrhage, injury to bowel, bladder, cervix, blood vessels and broad ligaments. These complications are 5 to 10 times more likely. Pain is greater for caesarean section than vaginal delivery and the recovery period is longer. There are also more difficulties with future pregnancies.4 These problems include a substantially higher rate of difficulty conceiving, miscarriage, and stillbirth. Women who have had a caesarean section have fewer children than women who deliver vaginally. They are less likely to breast-feed and if they do breast feed they will breast feed for shorter lengths of time. Women who deliver surgically have also been shown to provide less tactile stimulation, caretaking and intimate play with their babies. As one medical paper has stated 'Surgically delivered children may begin their lives at a disadvantage'5.

A recent study from the US found that, if there were no risk factors, the baby was 2.9 times more likely to die if delivered by caesarean section.6 Babies delivered by caesarean also have a higher risk of respiratory distress syndrome, persistent pulmonary hyper tension and an increased prevalence of childhood asthma2. A recent paper by two American authors reviewed research on the psychosocial effects of caesarean sections and found that there was lower satisfaction consistently documented by mothers who had been delivered surgically. They worried more about the baby's condition and experienced more fear during the delivery. After the birth they were more likely to suffer loss of self-esteem and loss of body image than those who delivered vaginally. They reported feelings of powerlessness, lack of control or traumatic experience. Feelings of failure and self-blame were also reported. Some women likened the experience to torture.5

Caesarean deliveries may be uniquely distressing because they combine surgery and childbirth, events which on their own usually evoke quite different responses. A woman may feel neglected after the surgery and it is commonly related how comments such as 'Why are you so upset? Your child is healthy.' demonstrate a lack of sensitivity towards women recovering from major surgery. Many women are reluctant, initially, to acknowledge anything negative about the birth, in part because of societies pressure to behave as if they are happy as long as the baby is alive. Because they are forced to deny their own feelings some women do not express negative feelings about the birth until weeks, months or sometimes years after the birth. My own experience from those who contact AIMS is that women's reactions when they become pregnant again are 'I don't want to feel the way I did after the last caesarean. How can I stop them doing that to me again?'

Recently there has been a marked increase in the number of women contacting AIMS who wish to avoid caesarean section or repeat caesarean section. They have been ignored or bullied by professional staff who have refused to accept the woman's wishes and may even threaten to withdraw care. Under the pretence of providing information they warn of risks, which include pain, death, haemorrhage, ruptured uterus, colostomies and anything else they can think of. One quite dreadful tactic employed in Newry,

during August 2007, was forcing a woman to sign a number of 'consent forms', at 38 weeks, which she was not allowed to seek advice on. The forms rehearsed the 'risks' of a VBAC at home, although these had already been repeatedly discussed. The risks listed in the forms were grossly over stated and misrepresented the mother's wishes for her delivery. I understand that a deskilled midwife who lacks confidence may be fearful but it is highly unprofessional to project those fears on to one's patient.

There are few if any times in one's life when one is more vulnerable to bullying than when heavily pregnant. To be badgered, berated and belittled by those who should be supporting and encouraging a pregnant woman is a travesty of trust.

But this fashion too will pass. Already the centres for disease control and other American Health agencies have targeted a reduction of the caesarean rate for women having their first babies to 15% by the year 20107. Closer to home some hospitals are tr ying to reduce their induction rates in an effor t to limit the caesarean sections, which result from the cascade of inter ventions, which follow an induced labour. But there is much more which could be done.

Midwives need to reclaim their role as the experts in normal birth and re-skill themselves in the art of midwifery. Prime amongst those skills is the ability to build bonds of trust with the woman they are caring for. They need to instill the confidence needed for a successful labour instead of shroud waving and to that end they need to be supported in turn by their supervisors of midwives. Professionals must learn that birth is not an ephemeral event. A woman who has a good birth is endowed with the confidence born of that success and this success fosters the faith that she can mother the child. A woman who feels an element of failure, as a result of a bad birth, is unlikely to face the next 20 years of mothering with the same confidence.

In asking professionals to trust women's bodies and respect their wishes I acknowledge that, yes, some times things go wrong but it's more likely to happen when arrogant professionals tamper with spontaneous events. I close by reminding us all the words of Naaktgeboren8

'The safest way to help labouring women is to respect nature and not to interfere with spontaneous events unless there is clear evidence that to do so would be beneficial. It is a dangerous practice to underestimate the spontaneous reactions and the innate biological behaviour of the parturient woman.'

**References**

1. WHO (1985) Consensus Conference on Appropriate Technology for Birth quoted in Wagner, M (1994) Perusing the Birth Machine Australia: ACE Graphics p.346.
2. Wagner, M (2000) Choosing Caesarean Section The Lancet 356,1677-1680.
3. Matthews, TG, Crowley, P, Chong, A, McKenna, P, McGarvey, C and O'Regan, M (2003) Rising Caesarean Section Rates: A Cause For Concern? British Journal of Obstetrics and Gynaecology. 110, 346-349.

4. Almeida, ECS, Nogueira, AA, Candido dos Reis, FJ and Rosa de Silva, JC (2002) Caesarean Section As A Cause Of Chronic Pelvic Pain International Journal of Gynaecology and Obstetrics 23, 743-756
5. Lobel, M and DeLuca, RS (2007) Psychosocial sequalae of caesarean delivery: Review and analysis of their causes and implications SOCIAL SCIENCE AND MEDICINE 64, 2272-2284
6. MacDorman, MF, Declercq, E, Menaker, F and Malloy, MN (2006) Infant and Neonatal Mortality for Primary Caesarean and Vaginal Births to Women with no Indicated Risk, United States1998-2001 birth cohorts Birth 33, 175-182.
7. United States Depar tment of Health and Human Services (2000) Healthy People 2010 Washington, DC: United States Government Printing Office.
8. Naaktgeboren, C (1989) The Biology of Childbirth Ch. 48 Effective Care in Pregnancy and Childbirth Oxford: Oxford University Press.