



Challenging the Medicalisation of Birth

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Beverley Beech talks about the difficulties in getting consumers' voices heard

The concept of 'consumers' in maternity care began to develop in the 1960s when, in the UK, three national groups involved with childbirth were established. The Natural Childbirth Association (founded in 1956) became the National Childbirth Trust (NCT), and Mother Care for Children in Hospital (founded in 1961) became the National Association for the Welfare of Children in Hospital (NAWCH), and then, in 1991, became Action for Sick Children. AIMS too was founded in 1960, and originally called the Society for the Prevention of Cruelty to Pregnant Women. All of these organisations were established as a result of an initiative from individuals who felt that something had to be done about the services at that time.

AIMS provides information and support to anyone who asks for it. Our telephone helpline, website and email facility, and the help and advice we give to women who intend to complain about their care, keep us in touch with ordinary women and alert us to trends and emerging problems.

The process of writing up the history of AIMS for my address at the 50th Anniversary Luncheon was a depressing exercise. The letters the women wrote in the 1960s are little different from the letters written today. Maternity care in the UK, as in much of the Western Hemisphere, is dominated by obstetricians, who have moved from a position where they were called in to assist with a problem labour to the current situation where they control the majority of pregnancies and births. They have done so by persuading the population that childbirth is inherently dangerous, that women's bodies do not function well, by undermining their confidence, by claiming that only obstetric care will guarantee a healthy baby and, worst of all, by carrying out what is now an international witch hunt to remove those midwives who practise real midwifery. As a result of this control, women's voices are often ignored.

In the United Kingdom women were moved into hospital on the spurious grounds that: 'The greater safety of hospital confinement for mother and child justifies this objective.'¹ No-one asked the women if they wished to birth in hospital, and no evidence at all was produced to demonstrate the greater safety of hospital deliveries. This report claimed that 'sufficient facilities should be provided to allow for 100% hospital delivery.' This gave the green light to the obstetricians to embark on a campaign to get every woman into hospital. Within twenty years the home birth rate had dropped from 33% to 1.2%.

In the 1960s AIMS members campaigned for more hospital beds on the grounds that there were not enough beds for the minority of women who really needed hospital delivery [in this article 'delivery' is used to describe birth where the woman is not at the centre of the decision making process]. It was not

until the 1970s that the organisation realised that, rather than providing quality care for truly high-risk women, the obstetricians had seized the opportunity to gain control of all births. Instead of women being cared for in the community by a skilled midwife, and referred to an obstetrician when the midwife detected a problem, all women were now required to book with a GP who invariably simply referred her to an obstetrician. The community midwives were brought into a centralised hospital service and converted into obstetric nurses. Unfortunately, in the UK the system does not differentiate between an obstetric nurse and a midwife; they are all called midwives.

Early user attempts to influence the quality of care were met with resentment and antagonism. Fortunately, AIMS changed its title very early on in its existence; one can only imagine what reaction the women had when they announced they were members of the Society for the Prevention of Cruelty to Pregnant Women.

In 1961 the Ministry of Health published 'Human Relations in Obstetrics'. The Report highlighted what AIMS had been saying - including poor conditions, lack of support, lack of information and lack of midwives. The Minister asked hospital authorities to take action on antenatal clinics, companionship and information during labour, comfort and convenience of mothers and an injunction that these things should be put right. How ironic that this paper could be published today and most of its comments are still relevant. It was not until 1982, after persistent lobbying by AIMS, that the Department of Health set up a Maternity Services Advisory Committee to compile a good practice plan of action. It was to consist of representatives of each profession involved in maternity care and a sole 'consumer'. AIMS again lobbied for more than one representative for parents and a second person was appointed. This committee then published three guides to good practice and a plan of action² which included the recommendation to set up Maternity Services Liaison Committees (MSLCs) in every area.

These committees are supposed to have a balanced membership of professionals and users, but often they are not funded; users are expected to give their time for free and, not uncommonly, pay their own travelling expenses. The meetings are at a time to suit the professionals and there is a reluctance to pay child care. However, there are MSLCs that function well and have been instrumental in effecting change.

Early in its history AIMS members would draw the hospitals' attention to women's views and the problems women had with maternity care, but these were usually dismissed as a minority of disgruntled women and the claim that the procedures were necessary.

For example, Herbert Barrie, a consultant paediatrician, said:

*'A steady but growing trickle of strange ladies is infiltrating the system and arriving in labour wards up and down the country with a familiar shopping list of demands telling doctors and midwives what to do.... These patients tend to arrive, without warning, in the Labour Ward with their lethal shopping lists.... They are not entitled to tell doctors how to do their work. They are not entitled to ask us to lower professional standards and to jeopardise babies' lives.'*³

Over the years, such attitudes have changed although in a recent radio interview an obstetrician was

reported as claiming that the current problem with maternity care is 'childbirth groups of vociferous upper class women'.

The 'shopping lists' to which Barrie referred were Birth Plans. They were an attempt by women to have some control over their labours. AIMS members have some ambivalence about these plans as research has shown that when they are presented in hospitals to staff that the women have not met before, they are often ignored and those women have been shown to have more interventions than those who did not present a plan. In commenting on this the researchers asked, 'Could patients with birth plans be receiving less support and encouragement throughout their labour than patients without birth plans?'⁴ They did not explore why the staff had such attitudes and what could be done to improve them.

The discrepancy between what obstetricians were telling us and what the women said led our members to go into the medical libraries and start reading the research, and they were shocked to find that very little obstetric practice was based on good research.

Episiotomy

Episiotomy is a classic example. It was developed in the USA where it was vigorously promoted on the spurious grounds of 'protecting the fetus'. A great deal of emotive claims were made, for example:

'...every minute the baby's head is on the perineum two points can be deducted from its IQ.'

'The fetal brain suffers prolonged pounding and congestion in a hard spontaneous delivery with possible brain damage and anoxemis [sic] or asphyxia.'

'The descent of the fetal head was also compared to the mother falling on a pitch fork which pierces the perineum, and the baby having its head crushed in a door.'

Needless to say, none of these statements was true, but they justified the expansion and widespread use of this western form of genital mutilation.

Routine episiotomy was widely used in the USA but it was not adopted in the UK until the 1960s when use began to rise dramatically. By 1967 it had reached 25% and by 1978 it had reached 53.4%. Some London teaching hospitals had a 98% episiotomy rate and we even have examples in our files of women who were given an episiotomy after the baby was delivered because the midwives were afraid of criticism for failing to do one. Needless to say, there was no good research showing the benefits of episiotomy; it had been introduced following a persistent medical campaign without any evidence demonstrating benefit when used routinely.

Sheila Kitzinger published a booklet about the physical and emotional impact of episiotomy. The persistent consumer criticism of episiotomy, now echoed by some professionals, resulted in Jenny Sleep, a midwife, being enabled to conduct a study, one of the first research studies conducted by a midwife. It found that routine episiotomy did not prevent tears, did not protect the baby, and did not prevent infections, and furthermore it gave us a research paper that we handed over to women who did not want

episiotomies.⁵ Women then started quoting the research to professionals. We also advised them to ask one specific question when being told that they had to agree to a specific procedure: *'Can you give me a copy of the research paper that supports what you are saying? I will then read it and let you know my decision.'* So often there is no research to support the advice.

Ultrasound

In 1994 AIMS published a critique of ultrasound (Ultrasound? Unsound). It is the only critical review of ultrasound research in existence. Ultrasound has been promoted as a safe technology and governments spend inordinate amounts of money exposing pregnant women to it. AIMS had been alerted to potential problems by a research paper from the USA by Dr Dorothy Liebeskind, Assistant Professor of Radiology at the Albert Einstein College of Medicine, USA, and published in RADIOLOGY in 1979, about the effects of diagnostic levels of pulsed ultrasound on the growth pattern of animal cells which persisted for many generations.⁶ This was followed by other papers which showed changes in the surfaces of cells and in 1982 she noted 'the persistence of abnormal behaviour.. in cells exposed to a single dose diagnostic ultrasound ten generations after insonation' and concluded 'If germ cells were involved, the effects might not become apparent until the next generation.'

It had become fashionable and convenient - to dismiss Liebeskind's work because a number of other centres were not able to replicate it. But four researchers elsewhere have done so. It was not replicated by two who did not use pulsed ultrasound.⁷ And one might ask, is there a connection with dyslexia or attention deficit disorder? Of course there could be a multitude of other causes, but, where ultrasound is concerned, that question cannot be answered because good-quality ultrasound research has not been done.

Health - Dr Gerard Vaughan - telling him of our concern about the widespread use of ultrasound before it had been evaluated. To our astonishment he replied that the Medical Research Council had considered the possibility of a trial to assess potential benefits and hazards of using ultrasound in pregnancy in 1976 and had rejected it:

'In the four years [sic] since then, the use of ultrasonic techniques have become so widespread that a controlled trial along the lines originally proposed would no longer be ethically possible.'

It was, apparently, 'ethically possible' to expose almost every unborn child in the United Kingdom to a procedure whose safety had not been evaluated - and is still not properly evaluated more than thirty years later.

Had a proper trial been under taken, we would now have had children up to 18 years old followed up for possible long-term effects.

A randomised study of 2,475 women reported a fourfold increase in perinatal deaths in babies exposed to routine Doppler ultrasound examination of umbilical and uterine arteries at 19-22 weeks and 32 weeks (16 v 4 perinatal deaths of normally formed infants)⁸

The results of a large trial from Helsinki were published in The Lancet.⁹ Over 9,000 women were randomly divided into groups which did or did not have routine early ultrasound scans. There were 20 miscarriages after 16 to 20 weeks in the screened group and none in the controls. Our letter to The Lancet pointing this out was not published and the authors of both these studies have not responded to our questions on this surprising difference.¹⁰

Intrauterine growth-retarded (IUGR) babies

In 1998 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.¹¹ Out of 2,378 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 growth-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%). Pre-term delivery was five times more frequent in those whose IUGR was diagnosed before birth than in those who were not. The average diagnosed pregnancy was 2.3 weeks shorter than the undiagnosed one. The admission rate to intensive care was three times higher for the diagnosed babies.

This important study shows a huge difference between the 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 routine scans are not benefiting babies.

AIMS continues to campaign for a reduction in the routine use of ultrasound but while the public continues to be misled by statements such as these, we have a hard battle on our hands:

'Some 100 million people throughout the world are walking around having had scans before they were born, and there never has been a shred of evidence that it does any harm.' **Professor Stuart Campbell, Sunday Times, 10 June 1984**

'There are 50 million people walking around today who were scanned in the womb, and there is not even laboratory evidence to indicate that it is a hazard.' **Professor Stuart Campbell, Mother and Baby magazine, May 1990**

The observant amongst you will have noticed that between 1984 and 1990 Professor Campbell has

managed to lose 50 million people.

Caesarean sections

The caesarean section rate in the UK is a national disgrace: in some hospitals it has exceeded 30%; the national average is over 23%. The World Health Organisation has pointed out that there is no health improvement when caesarean sections exceed 10%. When AIMS expressed concern about the rising caesarean section rates in the 1980s we were told not to worry - they would never reach 10%. Rather than focusing on changing the provision of maternity care (women having home births or birth centre births have very low rates of caesarean sections) the obstetricians justified caesareans by claiming that women were 'choosing' them or that they were 'Too Posh to Push'. It is our experience that many of those women who have 'chosen' a caesarean have done so because they have been so traumatised by an earlier birth that they think a caesarean will be better. We have found that after discussing why the birth was as it was, the majority of women then choose to have a vaginal birth. Posh Spice made the mistake of booking into a private obstetric unit (these have the highest caesarean rates of all) with her first baby presenting by the breech - so much for choice. Claiming that women are 'choosing' caesareans deflects any discussion of changing the provision of maternity care to a system that has been shown to improve outcomes.

Maternal death

Every three years the Confidential Enquiry into Maternal and Child Health publishes its review of maternal deaths. Initially deaths were categorised by cause of death but AIMS lobbied the Enquiry to look at deaths up to three years following birth. The Enquiry extended its remit to look at deaths up to one year after birth and found that 'suicide was in fact the leading cause of Indirect or Late Indirect maternal death over the whole year following delivery.'¹² Suicide was the largest cause of maternal death - greater than thrombosis, infection, haemorrhage, and other well-known causes. This discovery led to better identification and treatment - but not to prevention. We have seen in recent years a huge increase in postnatal depression and post traumatic stress, the causes of which, we believe, include traumatic interventions and insensitive treatment in childbirth.

While obstetric units provide excellent care for women and babies with problems, those women and babies who have no problems are subjected to any unnecessary interventions that a medicalised system favours. Women are often traumatised by these experiences and, as the research shows, increasing numbers of them suffer unnecessary caesarean sections and operative delivery, postnatal depression and post traumatic stress, failure to breastfeed and subsequent difficulties in bonding with their babies.

Cot deaths

Recently Jean Robinson drew my attention to her report of a fascinating study from Munster which has shown that cot deaths were far lower in East than West Germany - because the East Germans discovered that prone sleeping caused sudden infant death as early as 1971. It took the West 20 years to make the

same discovery and implement change.

When East and West Germany were reunited in 1991, the East Germans had worse health, higher perinatal mortality and lower life expectancy, but they had a much better record in one area - post-neonatal mortality. The death rate in babies had been lower than in the West by 1 per thousand for 20 years but it increased sharply after reunification.

East Germany had an excellent system for monitoring child deaths, including expert autopsies after the death of every child under 16. They, like everyone else, followed medical recommendations that mothers should put babies to sleep face down. However, in 1971 seven babies died in this position in day care. This led to a number of meetings held by the Ministry of Health. They issued guidelines forbidding putting babies in this position without permanent supervision, during sleep, wearing restricting clothes, lying under a duvet, in a pram, for three hours after feeding, when tired, or during illness. They were only to be prone for muscular training while awake and supervised. The post-neonatal mortality rate in East Germany was among the ten lowest in the world, in spite of limited medical resources. Shortly after reunification, a 1991 survey showed that only 10% of babies in East Berlin were sleeping prone compared with 50% in West Berlin.

Why did the cot death rate rise after reunification? The authors suggest a number of answers. More mothers may have let their babies sleep face down due to West German medical influences, the maternal consultations system collapsed (women had previously been paid to attend these), plus the autopsy rate fell sharply. Twenty years before the 'Back to Sleep' campaign, East Germany had identified a major cause of SIDS and efficiently put a remedy into action. As we have pointed out, the epidemic increase in cot deaths was caused by faulty medical advice resulting in the deaths of many thousands of babies. Lack of communication between East and West prevented us from learning from East Germany and saving the lives of untold numbers of babies.

A Charter for Ethical Research in Maternity Care - October 1997

All over the world the medical profession carries out research on pregnant and labouring women, much of which is unethical as many women are encouraged to take part without being given adequate information.

During 1997 AIMS invited representatives of the National Childbirth Trust and Consumers for Ethics in Research to consider a draft charter for ethical research in maternity care. This set out conditions that women would find acceptable if asked to take part in research, including informing women of the reasons for the research; giving details of what the researchers hoped to find; clarifying what the risks, if any, were, and advising them of the results and follow-up.

This Charter was accepted by all the major medical Colleges, and, indeed, the Royal College of General Practitioners handed it out to all its student GPs.

Home birth

'The choice of home birth should be offered to all women.'^{[13](#)}

One of the longest and continuing campaigns has been for women to birth at home. Many obstetricians persistently claim that a hospital delivery is a safe delivery and home birth is dangerous. These claims are based on false statistics and fail to take morbidity into account. In the past, the statistics counted any woman who birthed outside a hospital as a 'home birth'. As a result, women having their babies in prisons or remand centres and women who unexpectedly gave birth at home or who had concealed their pregnancies - all of whom are very high risk - were counted as having a 'home birth'.

In 1985 Marjorie Tew, a respected statistician, exposed the myth that birth in hospital is safer than birth at home when she published her statistical analysis of home v hospital birth and revealed that, in every single risk category but one, it was safer to birth at home than be delivered in hospital. Since that time there have been no reputable studies that have been able to challenge her analysis.

As Marjorie Tew has stated:

'The threat of home birth is not a threat to mother and baby, but a threat to the healthy survival of obstetric and medical practitioners.' ^{[14](#)}

Following Marjorie's study AIMS changed tactics: it no longer campaigned for home births on the grounds of a woman's right to birth where she chooses but instead campaigned on the grounds of safety. Unfortunately, the safety of home birth is not acceptable to many members of the medical profession, particularly the American College of Obstetricians and Gynecologists, which is notorious for its opposition to home birth.

Its latest piece of questionable research was published in the American Journal of Obstetrics and Gynecology which concluded that '*Less medical intervention during planned home birth is associated with a tripling of the neonatal mortality rate.*' ^{[15](#)} Needless to say, it was taken up and quoted by the medical journals in the UK and the national newspapers. While consumer groups, all over the world, challenged the findings and showed that the conclusions were not supported by the study's own data, very little of the counter-evidence has been highlighted by the newspapers and we await with interest any further comment in the medical journals.

Normal birth

The most successful AIMS campaign has been about normal birth. In 1997 I wrote an article in the AIMS Journal, 'Normal birth - does it exist?',^{[16](#)} in which I pointed out that very few women experienced a normal birth in hospital because of the amount of intervention to which they were subjected. It was not uncommon for women to tell us that they had a horrendous delivery the last time and they 'never want to have a normal birth ever again'. It transpired that many women had been told either that labour needed

starting off, or that as labour had slowed down a drip would be put up to 'get you going again'. Before long the pain of induction or acceleration was intense, and made worse by continuous electronic fetal monitoring requiring the woman to lie on the bed and remain still. The women started asking for pain relief and eventually an epidural would be set up. If the woman was lucky she might be able to push the baby out, but would probably have an episiotomy in the process and the placenta would be delivered by active management. The staff would then write 'normal delivery' on her notes when the birth was in reality a long way from the AIMS definition of Normal Birth, which is: spontaneous onset and progression, with no breaking of waters, no drugs to speed progress, no narcotic or epidural pain relief, no episiotomy, no instrumental or surgical delivery and no managed third stage. A tall order in the majority of our maternity units.

Research midwife Soo Downe undertook a survey of five consultant units in one region to test my claims on intervention. She found that only 1 in 6 women expecting their first babies and only 1 in 3 women expecting subsequent babies had normal births.¹⁷ The study excluded from the normal group women who had caesarean operations, general anaesthesia, forceps or ventouse, epidural, artificial rupture of membranes, induction or acceleration of labour, or episiotomy. It should be noted that the 'normal birth' group in this study still included women who had had electronic fetal monitoring, other drugs in labour or a managed third stage. So the true numbers of normal births are even lower.

For those who want to explore what normal birth actually means and what the effects are, I suggest they read Soo Downe's book *Normal Childbirth - Evidence and Debate*¹⁸ and Nadine Edwards's book *Birthing Autonomy - Women's Experiences of Planning Home Births*¹⁹ which 'explores the difficulties and tensions women and midwives experience trying to organise a home birth in a service that pays lip service to choice.'

The Good Birth Guide

In 1976 Ann Taylor, who was Secretary of AIMS at the time, suggested that perhaps we should publish a Good Hospital Guide, along the lines of the Good Pub Guide. Unfortunately, AIMS did not have the staff or money to undertake such an exercise, but Sheila Kitzinger did. In 1979 Sheila published the first edition of the Good Birth Guide²⁰ which gave star ratings to 300 hospitals in England, Wales and Scotland. Hospitals that had been dismissive of women's requests for information suddenly took a great interest.

The Maternity Defence Fund

The second very successful campaign was the one we launched to sue the medical profession for assault.

By 1982 the childbirth groups were becoming increasingly dispirited about the way in which women were being forced to accept treatment (usually pethidine, routine episiotomies and their babies being given bottled milk despite the mother's protests). It was decided that as every other avenue had been tried, all of which had failed miserably, the time had come for drastic action.

AIMS, the Society to Support Home Confinement and the Birth Centre Organisation decided to launch a fund (the Maternity Defence Fund) to sue the medical and midwifery profession for assault. Not only did it achieve a sea change, almost immediately; it did so by threatening to take legal action. For the first time ever, the professional journals published articles on patients' rights, informed consent, and long discussions of the issues involved.^{[21](#)}^{[22](#)}

There is no doubt that legal action, and the threat of it, has provoked more changes for the better in obstetric care than any other action. It is the only sanction available to parents that the medical profession takes seriously. But legal action is a double-edged sword. Just as some obstetricians justify their practice by claiming that 'this is what the consumers demand,' so too do many obstetricians claim that the increase in technological intervention, particularly caesarean sections, is a conservative response to the threat of litigation. No-one questions the ethics of openly claiming that the reason one does a caesarean section has little to do with the best interests of the mother, but is to protect the individual from potential litigation - overlooking also the fact that successful litigation depends upon a provable case of negligence and very few litigants in maternity care are successful.

Association of Radical Midwives and MIDIRS

In 1972 the Association of Radical Midwives (ARM) was formed, with the aim of returning midwifery to its roots. Those midwives who joined this organisation, or who espoused its beliefs, often suffered considerable harassment, not only from obstetricians, but also from many of their own colleagues, who, with the passage of time, had become obstetric nurses.

In order to support and help ARM, the NCT and AIMS invited ARM members, or any midwife who was interested, to attend a monthly support meeting at the NCT headquarters to discuss issues in maternity care. This initiative increased midwives' confidence in continuing to practise real midwifery and, over a period of time, helped them establish their own networks and form a professional organisation.

Another significant initiative was taken by a small group of student midwives and members of ARM. They decided that there was a lack of scientific evidence relating to childbirth and so set up MIDIRS - Midwives Information and Resource Service - to disseminate information to midwives and encourage improvements in maternity care. This initiative has resulted in midwives and women all over the world having access to scientific research papers. Find them at www.midirs.org

Choice

In 1993 the House of Commons Select Committee published the results of its investigation into

maternity care.²³ This report acknowledged what women had been saying for years. Care was over-medicalised and women needed more midwives, fewer interventions and more community based-care. The Government's response was to set up a committee and suddenly everyone was talking about 'choice'; and choice is still the mantra repeated today.

If women are to make choices they have to be properly informed and unfortunately very few women are; they rely on officially produced leaflets, TV and radio and women's magazines. None of these sources properly inform. It is little different from the woman who tells the supermarket owner that he does not have any choice of fish; he is bemused - of course they have fish - and shows her a huge array; she takes one look and says, 'But it is all frozen and I want fresh.' Research shows that at least 10% of women would choose a home birth yet fewer than 3% actually achieve one. Every hurdle possible is put in their way under the guise of 'informed consent'. While hospital staff are only too keen to graphically describe what they perceive to be the risks of home birth I have yet to hear of any unit that tells women the risks of hospital deliveries.

I became so cross about the focus on telling women the so-called risks of home birth that I produced a leaflet, available on the AIMS website, detailing some of the risks of hospital deliveries. It has been modified and has been copied in many other countries. Every woman should read one before she decides where to birth.

Over the years, criticism of obstetric care has had little effect on maternity provision. The drive to centralise obstetric units continues and local women are still fighting battles to keep their local birth centres open.

Postnatal depression

I mentioned earlier the damage that obstetric care does to women. Most of that damage is hidden. Women who have had episiotomies frequently report that their sex lives have been ruined. I have spent years failing to persuade sociologists to carry out a survey of divorced women to see whether their ruined experience of childbirth was a significant factor in their marriage breakup. When we ask women with serious complaints and problems following childbirth about the state of their marriage very few are able to say that their marriage is not under considerable stress.

For years AIMS has helped women with postnatal depression, but it was only after the vigorous use of induction and acceleration of labour that we began to see an increase in the numbers of women with post traumatic stress disorder, a very serious consequence of bad birth experiences.

Where mothers need inpatient treatment, there are far too few specialist mother-and-baby psychiatric units, where mother and baby are cared for together during treatment, and where bonding is supported so that when discharged they have not been separated and are ready for the outside world.

Providing one-to-one midwifery care based in the community would, we believe, make significant improvements in women's mental health and the health of their babies. The incidence of both depression

and PTSD will vary between hospitals, but is likely to be less with continuous midwifery care, midwifery units, and home births. Unfortunately this data is not collected.

The impact of childbirth on the health of women and babies cannot be over-estimated. Childbirth has the ability to strengthen women, to empower them, to enable them to protect their children. Try taking a baby chimpanzee or a baby gorilla from its mother and she will kill you. We have been socialised into accepting that anyone can take our baby and I am disturbed every time I see a film of birth where the baby is removed by the midwives and given back to the mother sometime later. We know from those women who have been able to compare a technological delivery and a normal birth that they have different feelings, and it is only women who have experienced these different births who are in a position to judge what effects those births created.

Lack of midwives

Currently in England there is an acute shortage of midwives; at least another 5,000 are needed.

Over recent years a small mountain of research has emerged showing better outcomes when women are cared for by midwives who support them during pregnancy, labour and postnatally. A recent book edited by Robbie Davis-Floyd et al gives an analysis of the negative effects of medicalised birth and the beneficial effects of midwifery care and concludes that 'Birth models that work improve the physiological, and the social outcomes of pregnancy and birth and save money'²⁴

Over the years, every proposal to improve maternity care the way that women want has been modified to limit its effectiveness. A rash of wallpapering and putting up pretty curtains followed women's demands for birth centres, so much so that it was labelled 'pretty wallpaper syndrome'. Instead of establishing free-standing birth centres, hospitals are now promoting 'birth centres' that are along the corridor or up the stairs. This gives the illusion of responding to women's needs while ensuring continued control of midwifery practice and a ready pool of midwives when the labour ward is short. The disadvantage is that only a very small minority gain admittance and midwives are not enabled to hone their skills properly caring for healthy women. In our current climate of financial restraints we are finding that this is used as an excuse to close these birth centres down and move women into ever larger obstetric units. The industrialisation of childbirth continues.

Unfortunately, the present structure of the NHS militates against implementing the kind of change that is now needed in response to research evidence. Whilst the current system of payment by results continues to pay a hospital more for a caesarean section than it does for a normal birth, the financiers will be unlikely to look favourably on a proposal to fund more midwives and encourage more normal births. The system of capital charges increases the cost to the hospital should it establish a free-standing midwifery unit. The addition of a unit which increases the numbers of normal births will result in the hospital suffering a double whammy. It doesn't look attractive to the policy makers, certainly.

The UK already has some of the largest maternity units in Europe and appears to be intent on centralising

even more to produce 'super units' delivering over 7,000 babies a year. Midwives do not like working in these units and there is no evidence at all that they improve the quality of care or have better outcomes, but that does not appear to concern the grey suits.

The book *Sustainability, Midwifery and Birth* contains an interesting statement:

*'From a total cost-benefit perspective where financial, environmental, emotional and other short- and long-term costs and benefits are adequately considered as indirect as well as intangible costs, it would be difficult to uphold the current medical maternity model as one that is either efficient or sustainable.'*²⁵

The time is now ripe for action. If midwifery is to develop into the profession that is truly with women and responsive to their needs then midwives have to join with women and sympathetic doctors and demand change. Together midwives and women can make a formidable force for change. Until that happens we will only achieve marginal change. What is needed now is radical change and childbirth returning to a nurturing, supportive and humane system in which women are well informed and their decisions fully supported.

For those who missed the celebration, Beverleys address to the 50th Anniversary Luncheon is in *AIMS Journal* 22(4) and [on the website](#).

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