AIMS For a better birth...

# Over-Medicated and Under-Informed: What are the consequences for birthing women?

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It is not necessary to remind readers of the circumstances which empower a woman to give birth successfully. Birthing in her own surroundings, attended by people she knows and loves, having confidence in her ability to birth the baby and having confidence in a skilled practitioner who will be responsive to her needs and supportive of her decisions.

In our society we have lost the community rituals and rites which acknowledge a woman's passage from girl to woman. All we have left is the most important rite of all - giving birth. But for many women that rite has been taken over by a set of rituals and practices which have nothing to do with empowerment and a great deal to do with power and control.

No-one would deny that there are women and children alive today who would not have been alive were it not for the activities of obstetricians and modem technology. However, over the last ten years obstetric claims have come under close scrutiny and the evidence increasingly suggests that the major cause for the fall in mortality has been better housing, better sanitation, fewer children and a more educated population.

Women are inveigled into hospital by the honeyed words of safety and the technology is there just in case you need it. The reality is somewhat different. Marjorie Tew's analysis of the infant mortality statistics in Britain revealed that had women stayed at home at the same levels as they did in the 1950s our infant mortality rates would be four points lower than they are. This means that in Britain alone over 3,000 babies die each year as a direct result of their mothers choosing to give birth in hospital (Tew, 1985 and 1990).

A flaw in the presentation of statistical data also clouds the facts. Babies aborted for congenital abnormality are not included in the perinatal mortality statistics, and the resulting fall in the statistics are then claimed to represent improved obstetric care. In fact a significant part of that fall has been due to increased detection and abortion of those babies, an unknown proportion of whom will have been falsely diagnosed, and will have had nothing the matter with them at all.

Universal hospitalised birth also had a profound effect on midwives. They became hospitalised and they too adopted hospital practices. Instead of being with-woman they became with-machine, and many of

them spent their time trying to mitigate the adverse effects of the technology. One of the effects of Changing Childbirth has been that everyone is really nice to women and now they are "consenting" to even more interventions. To the extent that the obscene levels of unnecessary justified on the grounds of "women's choice"

The doctors were in control, they determined the protocols, they conducted the research, they have the ear of Ministers and social access to the corridors of power, and they dictated what care each woman should have. Birth, for the majority, has changed from all active, participatory and intensely emotional and empowering experience to an inactive, prone, extraction where women lost confidence in their bodies and were grateful that the doctor had saved them from the disaster they had just caused, and in the meantime midwives are doing their best in the face of staff
shortages and unethical protocols to help the women cope.

Technology has a place, and most of it was developed by caring doctors who were desperately trying to help those women and babies with problems. The tragedy is that once a new breakthrough is announced every unit which prides itself as being "a centre of excellence" rushes to introduce it immediately and extend its use to everyone. Unless of course, it is something women want, such as water birth, in which case every obstacle possible is put in the way. Today we are still struggling to answer the question: what constitutes appropriate technology? Often we are only able to answer the question through negative examples; looking at the many everyday examples of inappropriate use of maternity technology.

## Induction of Labour

One of the worst, and most intrusive, practices which we Europeans have enthusiastically exported all over the world, is the ritual of Active Management of Labour. As Jean Robinson, a childbirth campaigner of many years' experience and Hon. Research Officer of AIMS, has said, "it is the greatest export to come out of Ireland since Guinness". The manufacturers claim that "Guinness is good for you", although an excess is most certainly bad for you. So too is active management of labour. It has a function in very specific instances, unfortunately, for reasons which have nothing to do with the well-being of mother and baby it is used excessively (see p xx for discussion on the gap between evidence and practice), and women, in the meantime have little or no knowledge of the real reasons for its use.

While the medical profession, all over the world, took up this intervention with enthusiasm, often on the grounds that it reduced the caesarean section rates, they had little understanding of how Active Management of labour came about.

During the 1960s home birth in Ireland was discouraged, small maternity units were closed down and women were "encouraged" to deliver in very large centralised obstetric teaching hospitals. This gave the medical profession the advantage of plenty of women upon whom to practise medicine. During the 1960s it was accepted that a woman would deliver within 36 hours, by 1970 this time limit had been reduced to 24 hours and by 1975 the hospital was promising that no woman would have to labour longer than 12 hours. A very enticing offer, but the women were not told that this intervention would result in much more painful labours.

Active Management of Labour was promoted as beneficial. No-one would deny that there are women who will need to have their labours induced or accelerated, though few understood that having forced the majority of women into these large centralised units (in order to cope with the increased pressure 5,063 births in 1965 to 8,964 in 1981) the only option considered in order to guarantee one-to-one midwifery support for every woman in labour, was to reduce the time allocation on the labour ward for each woman. No study was ever mounted to find out if women wanted shorter but more intense and painful labours (O'Regan, 1999).

O'Driscoll's nightmare vision for the future was of large units, not less than 5,000 deliveries, where within a few years, labour would be completely controlled and managed like a military operation. It has been suggested that O'Driscoll's low caesarean rates were achieved because each woman had the continuous presence of a trained midwife. Hospitals all over the world introduced the active management package without proper midwifery support and none of them achieved the desired result.

## Electronic fetal monitoring

An intrinsic part of Active Management of Labour is continuous electronic fetal monitoring. Since the 1970s AIMS has been questioning the validity of this technology. There have been nine randomised controlled trials showing that EFM does not work, cannot be interpreted properly and is associated with an increased risk of cerebral palsy (Shy et al, 1990).

By relying on the monitors the skills of the midwives in using a Pinard or stethoscope are reduced, and staff shortages are coped with by putting the women on monitors instead of providing them with essential continuous midwifery support. A study at the John Radcliffe Hospital, one of the most prestigious hospitals in the world, showed that the staff failed to react more quickly in dangerous situation than they did when less risk was indicated, they failed to carry out further tests which were indicated and very" abnormal tracings were not recognised for almost eight hours (REF).

If the staff at this hospital have difficulty interpreting EFM what chance do staff have in less prestigious units? And if a midwife is desperately trying to look after three women in labour at the same time, is it any wonder that she overlooks even the most obvious adverse monitoring trace? The women, in the meantime, are not told how painful, disempowering and intrusive continuous electronic fetal monitoring is or that the benefits derived from this technology are minimal (Thacker et al, 1995 ). For the baby EFM can be fatal.

Few women realise, or are told, that a fetal monitoring electrode is a double-ended needle which is screwed into the baby's scalp, and it is responsible for permanent scarring, bald patches on the baby's head. Occasionally a baby dies as a result of infection entering through the wound and mothers have suffered internal injuries as a result of having the clip attached to them instead of the baby. Few mention the risk of the baby contracting HIV infections via the scalp electrode.

Part of the Active Management package relies on the use of partograms. Birth by graph. Every woman is required to fit into an artificially constructed straight jacket which presumes that all women will labour at a particular rate and within a particular time period. It does not allow for the "deviant" women who gently labour in fits and starts, whose body decides to take a break. Women are no longer allowed to have long labours. Short and painful is the order of the day, and it has become so common that public perception is that labour is continuous excruciating pain from beginning to end, and if women have Active Mangement that is exactly what it is.

## Drugs

Few women are able to cope with the added pain of induction and electron fetal monitoring without resorting to pharmacological drugs. Throughout their pregnancies women are exhorted not to smoke, take drugs or do anything to harm their babies. In America it has reached such a pitch that a pregnant women having a glass of wine in a restaurant will be berated and considered totally irresponsible. However, the moment a woman goes into labour obstetricians and midwives have few qualms about using very powerful synthetic drugs, and only now is the evidence emerging of the possible serious long-term effects.

In a well designed case control study children exposed to pain relieving drugs in labour were compared with those who were not, and an increased risk of drug addiction in later life was discovered. (Jacobson et a1, 1990)

In a more recent paper in the British Medical Journal they compared patients who had died from opiate addiction with brothers and sisters and found that if the mothers had opiates or barbiturates or larger doses of nitrous oxide the risk of opiate addiction to the child in later life was increased 4.7 times. (Jacobson et al, 1990 - CHECK).

A recent study of pethidine and morphine (Oloffson, 1996) revealed how ineffective they were and there have been suggestions that their continued use is unethical. Sadly, in drawing attention to the

ineffectiveness of these drugs the researchers went on to suggest that epidural anaesthesia was an effective alternative and was "good for the baby". Clearly, they had not read the research.

## Epidural anaesthesia

When women clamour for more epidural anaesthesia they often do so in the belief that this wonder drug will remove all pain, will not get through to the baby, and will ensure that they have a tranquil, placid, pain-free birth during which they can do The Times crossword or catch up on their knitting. For many women this is the reality, but for a large number it is not.

In the first edition of my book Who's Having Your Baby? I drew attention to the problems women experienced following epidural anaesthesia: "Little is known about the long-term effects of epidurals but following the public attention given to a mother who was paralysed and in a coma as a result of an epidural, Health Rights received letters from 70 women describing their experiences. one of the major complaints was backache, .....Many of the women had very serious headaches and for some, the headaches continued at intervals for years. Some of the women complained about tingling sensations in their limbs or areas of numbness. Had there been adequate research into this technique we would now know whether any of these conditions were a direct result of epidural anaesthesia and how many women it affects each year."

Studd demonstrated that epidural anaesthesia was responsible for a 20-fold increase in rotational forceps deliveries and other studies have shown an increase in the caesarean section rate (REF).

Rosenblatt in her study showed that the drug has significant effects on the baby in the short-term, it showed that the babies, at six weeks suffered decreased visual skills and alertness, poorer motor organisation and physiological response to stress and control of their own state of consciousness, but even she only checked up to six weeks (REF). We still have no way of knowing what are the long-term effects over the next 20,30, 50 years?

Epidurals have also been shown to cause intrapartum fever greater than 100.4° in 14.5% of women (Lieberman et al, 1997). It is interesting how the introduction of pools for pain relief and birth has been blocked, or withdrawn, by many hospitals on the grounds that the temperature of the water could cause a rise in the mother's body temperature and cause brain damage in the babies. Not a single paediatrician has suggested withdrawing epidural anaesthesia because of the risk of brain damage in the babies.

## Episiotomies

Women in developed countries ex-press horror at genital mutilation of women in Third World countries, but women in the developed world have suffered genital mutilation for decades, and it came about, not from a long- standing custom, but because, as Ian Graham revealed in his excellent book Episiotomy - Challenging Obstetric Interventions (Publisher?). American obstetricians vigorously promoted it and its use was before long routine in the majority of hospitals.

At one time almost 95% of women in Britain had an episiotomy during the birth, undertaken by midwives;

some women even had one after the baby had been born, because the midwives were afraid of the disciplinary action they would face should they refrain from doing one.

It was because of consumer pressure that midwife researchers were able to undertake research into the value of routine episiotomy and found that there was no justification for its routine use. When they did a follow-up study of perineal pain they found that 1 in 10 women had problems and 1 in 5 had pain with the new suture material.

## Ultrasound

In the past, it was difficult to examine the baby in utero. The doctors and midwives had to rely on what women told them. With the development of ultrasound women moved from a position where they relied on their feelings, intuition, knowledge of their own bodies and old wives tales to a reliance on the doctors telling them about their baby. To the extent that most women feel they have to go to a doctor to confirm that they are pregnant and rely on ultrasound to reassure them that their baby is alright. Few of them understand that the purpose of ultrasound is the opposite, it is to detect those that are not alright and abort them. Women dc not understand either, that ultrasound does not check that the baby is alright, it screens for specific abnormalities and is successful in detecting them with a wide range of accuracy. The baby may not have problems which ultrasound can detect, but it may have other problems.

Women are not told that when they have an ultrasound examination they and their babies are taking part in the largest unevaluated medical experiment in the world.
It is widely used for research, monitoring development of the fetal brain and organs from the earliest stages. We see many published research papers where studies have been done on movements of the fetus in utero e.g.. breathing, thumb sucking, swallowing etc. which are carried out for up to an hour or more at a time. No concern is expressed about possible damage or the need for long-term assessment of exposed infants.

When we talk about "diagnostic levels of ultrasound" we should make it clear that these are usually not measured and they vary widely between different machines and different makes. Users do not actually know the extent of exposure a baby is receiving from any individual machine.

Ultrasound is an unevaluated technology. It has never been subjected to a large-scale randomised controlled trial to establish its safety, and it is being developed so quickly trials published today are already out of date and difficult to apply to current machines because of the speed of change.

Since Lieberskind published her paper showing that ultrasound can alter the structure of cells for up to ten generations AIMS has been worried about the proliferation of ultrasound, and ourbooklet Ultrasound - Unsound? spells out the adverse effects of ultrasound and consumer anxieties.

Thacker, in his review of ultrasound, concluded that there is "no statistically significant reduction in perinatal morbidity and mortality associated with the routine use of ultrasound." (Thacker SB, 1985). I would suggest that not only is there no reduction in perinatal morbidity and mortality but that

ultrasound is one of the reasons why it is not falling.

Since Ultrasound - Unsound? was published, Doppler ultrasound, the most powerful form of ultrasound used in obstetrics, is now universally employed. We are worried because there have been three randomised controlled trials of Doppler ultrasound which showed significant increases in perinatal deaths and miscarriages. Davies (1993: 16 v 4) found a fourfold increase in perinatal death; in a large randomised controlled study Saari-Kemppainen (1990) found 20 miscarriages in the study group but none in the controls, and Lorenz (1990) reported a doubling of pre-term labour: 52% v 25%. None of the researchers have adequately explained these outcomes.

Trans-vaginal ultrasound, where a probe is inserted into the vagina so that the ultrasound can be nearer to the baby is being enthusiastically promoted. This ultrasound uses Doppler (incidentally those useful little hand held Sonic Aids use Doppler, but it has one small plus point, midwives are using it labour, and for relatively short periods) and there is no research looking into the potential adverse or long term effects of this new development.

So busy are the medical profession, researchers, pharmaceutical companies and electronics firms at promoting the benefits of these interventions and technologies the adverse effects are constantly minimised or trivialised.

## Adverse effects of medicalised childbirth

No-one has ever researched all the adverse effects of maternity care and collated them. Were it to be done the results could prove deeply shocking for those who promote medicalised birth..

Let me highlight just one example: An evaluation of the benefits of ventouse delivery compared with forceps delivery showed very clearly that the use of forceps should be phased out, except for very-specific cases. Those doctors conducting the study concluded that based on the assumption that about "50,000 women will require (in the UK) instrumental vaginal delivery every-year, the continued use of forceps as the instrument of first choice results, every year, in about 12,000 unnecessary pudendal blocks and other forms of regional anaesthesia for delivery, about 10,000 women unnecessarily experiencing moderate or severe pain during childbirth, 5,000 more women with severe perineal or vaginal trauma than there need be, and 3,500 women suffering unnecessarily from severe pain for several days after delivery. (Chalmers JA and Chalmers I). And that is just the mothers! The study did not examine the babies.

Furthermore, no-one has yet suggested that women could protect their perineums by avoiding hospitals which use forceps. Instead they are told that a caesarean section will protect them from perineal damage.

## The propaganda machine

The public presumes that the technology al1d routine interventions routinely used in maternity care have has been properly evaluated. Yet very little has, and even when information is available about the adverse effects, very few women are told about it. The hospitals produce glossy booklets promoting the

advantages of epidurals, ultrasound, whatever, none of them make any more than oblique reference to the fact that they all have unwanted adverse effects to a greater, lesser, or unknown degree,

The successes of obstetric care represent the tip of a very large iceberg, but undemeath that tip are massive amounts of iatrogenic morbidity. The technologies developed to protect and save the few, when used on the majority, create their own morbidity and mortality. Women who feel that they are getting sub-standard care because they have not had their routine ultrasound or routine electronic fetal monitoring are almost always unaware of the disadvantages and uninformed about the very real risks.

While women continue to leave hospitals with their newborn babies for all to see, few will see the damaged perineums or the emotional trauma. Women who complain are dismissed as a minority, but no-one has researched the extent of the damage. No-one has investigated how many marriages have broken down because the experience of childbirth has resulted in women whose sex lives have become difficult or impossible. How many women leave hospital convinced that "the doctors saved my baby's life" unaware that they had unnecessarily put the baby's life in peril in the first place, and were merely saving it from the potential disaster they had just caused?

How many women leave hospital convinced that they had to have their labour induced or accelerated because: the labour had stopped or they were not progressing, when in fact their bodies wanted to take a well earned rest; they were in no danger, neither were the babies; or that the staff wanted to get them through the system as they needed the bed, a result of the pressures of staff shortages and too many women coming into hospital or coming into hospital too early?

Hospital birth is medicalised birth. A woman wanting a "natural" or "normal" birth will find such a thing almost impossible to achieve in modern hospitals. This in part has led to the belief that "natural" and "normal" birth is a myth. Throughout the world the assumption of the safety of hospital birth is accepted without question - even though copious evidence suggests that birth, as practised in modern hospitals throughout the world, is not only abnormal but probably unsafe. We must continue to challenge this assumption for the benefit of each new generation of mothers and midwives until our voices are heard.

***Notes:***

**Ethical Research**

As I mentioned earlier, one of the great advantages of large, centralised, matemity units is that it offers doctors the opportunity to undertake research without too much trouble. They have a captive collection of guinea pigs, and as New Zealand women found to their cost public exposure of cervical cancer research revealed just how much the women who had the misfortune to be involved with this unethical research were treated as guinea pigs (Coney S, 1988).

All over the world women in pregnancy and labour are recruited into medical research, much of it unethical and of little value. The research agenda is set by the medical profession which requires any doctor who wishes to climb the professional ladder to undertake research. Now that midwives are taking degrees there is pressure there too for them to do research.

Trying to get research done which the consumers want is an uphill battle. Where is the randomised controlled trial of water birth, who is researching the possible link between the huge amounts of drugs used in the labour ward and subsequent drug addiction in teenagers? Who is researching the long-term effects of medicalised birth?

As consumers, we decided that it was time that women set standards for research so AIMS invited representatives of other childbirth and ethics groups in the UK to discuss a Charter for Ethical Research in Maternity Care (AIMS and the NCT, 1997). This Charter sets out standards which consumers should expect when invited to take part in research. When a pregnant woman consents to be a research subject she is consenting for two people, herself and her baby, and the full effects of which may not be known for years.

While midwives may not be undertaking their own research they are nearly always required to assist with research, informing the women about it, undertaking some of the necessary procedures and supporting the doctors efforts. When that research is unethical a midwife has a professional responsibility to speak out - how many do?

It took almost two years to develop this Charter, and some of us underwent a very steep learning curve. Some of our Committee already served on local ethics committees, one of us is on the national Multi Centre Ethics Committee, and most of the committee had long experience of patients' rights and research issues. So, when some professionals criticised the Charter as having been produced by people who had little understanding the difficulties. However, we were able to refute their criticisms.

The Charter has been widely distributed and has been welcomed by the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners and a large number of ethics committees throughout the UK. We have deliberately refrained from copyrighting it, so it can be developed to suit the conditions which apply in other countries and I hope midwives will adopt it a basis for their involvement in research, and by so doing may well change attitudes to research on pregnant women and babies.

As the Charter says "Research should be undertaken with women, not on women ".

## Home versus Hospital - What are the risks?

While this article does not focus on the difference in risk between home and hospital, this table is a stark reminder of just how big these differences can be.

| Risks of Home Birth | Risks of Hospital Birth |
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|---|---|
| Baby arrives before the midwife | Unnecessary breaking the waters |
| Unexpected complication which requires hospitalisation | Increased risk of infection |
| Midwife trained in obstetric deliveries | Unnecessary electronic fetal monitoring |
| | Unnecessary induction or acceleration of labour |
| | Complications caused by the above unnecessary procedures |
| | Mother and father left unattended when they need support |
| | Increased ventouse deliveries following epidural anaesthesia |
| | Operative deliveries carried out to resolve staffing shortages (at night and weekends) |
| | Caesarean sections carried out to rescue the woman from the increased forceps deliveries following epidural anaesthesia |
| | Operative deliveries carried out in order to train junior staff |