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Harsh Myths, Harsher Realities

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Jo Murphy-Lawless talks about maternal deaths in Ireland and the maternity services crisis

On the 28th June, 2011, there was a discussion about our maternity services on Ireland's premier radio news programme, Morning Ireland, during which Professor Michael Turner, former Master of the Coombe Hospital and currently National Clinical Lead in Obstetrics and Gynaecology, stated how excellent and how safe those services are, adding that Ireland has one of the lowest rates internationally of maternal and perinatal mortality.

These claims about the maternity services and, in particular, the canard about our having one of the lowest rates or even the lowest rate of maternal mortality in the world have been repeated so frequently and uncritically in so many different settings by politicians, medics, health service administrators, policy analysts and research midwives as to become an accepted 'fact'. For decades, Irish obstetricians had no compunction in dining out on this 'fact' as proof that their rigid control of maternity care worked best, despite the 'fact' being based on local and national data sets that were woefully incomplete. This same 'fact' even found its way into the 2008 UNICEF international report on maternal mortality.

However, there has been some recent disquiet and in 2007, Colm O'Herlihy, a professor of obstetrics based in the National Maternity Hospital, Holles Street, published a piece stating that our statistics should carry a 'health warning' because of 'significant under-reporting' attributable to the flawed data collection process.1 In 2008, a maternal death enquiry team, the Maternal Death Enquiry (MDE), was finally set in place to run as part of the triennial UK national confidential enquiry. A first report on Irish data was issued in August 2012. That report states that data collection continues to be incomplete due to the following factors:

- an 'inconsistent' approach to data classification on the part of coroners and the lack of a 'national approach to the notification of deaths',
- the need for a question on pregnancy status at time of death to be included on the coroner's certificate1
- 'uncertainty' about who has responsibility in community health services to report to the MDE,
- incomplete engagement on the part of some hospitals, mainly general hospitals because of concerns on the part of the latter about 'data protection, potential litigation, and anticipated review of cases by other agencies outside the MDE process.'2

In relation to that last, the report's authors add that 'in some hospitals' it was 'occasionally difficult' to

access data.2

To the above can be added:

- the absence of nationally observed protocols on serious maternal morbidity,
- the absence of a law requiring all possible maternal deaths to be subject to a coroner's inquest.

Given these problems, the composite figures on maternal deaths from 2009 to 2011 can be viewed at best as preliminary. The twenty-five maternal deaths the MDE has pinpointed over that three-year period give an approximate rate of eight per 100,000 maternities. This compares with 11.9 per 100,000 maternities in the UK for the period 2006-2009 and, on another scale of comparison, eight per 100,000 live births in France, seven per 100,000 live births in Norway and five per 100,000 live births in Sweden2 Thus, at best, our figures for maternal deaths are only average compared with near neighbours in Europe.

The MDE is funded by the Health Services Executive (HSE), the operational body for all health services in Ireland, on behalf of the government Department of Health and Children. It is an official body. Notwithstanding this, incessantly in the past six weeks, we have heard repeated in print, on the floor of the Irish Parliament, the Dáil, and on the airwaves by the current Minister for Health, by other politicians, and by administrators, journalists and commentators either that 'we have one of the lowest rates of maternal mortality in the world' or that 'we are one of the safest countries in the world where women can give birth'.

The renewed energy given to circulating this fiction is bound up with the tragic death of Savita Halappanavar on October 28 in Galway University Hospital (GUH), news of which broke on 14 November. Ms Halappanavar was seventeen weeks pregnant when she was admitted to GUH suffering back pain on October 21st. She was told that her pregnancy was not viable and that she was miscarrying. News of her death one week after her admission, from suspected E.coli ESBL and septicaemia became an international scandal: she and her husband had both asked for this unviable pregnancy to be brought to a conclusion when the miscarriage process, with accompanying pain and physical distress, began to stretch beyond a day, rather than the several hours initially said to be likely by attending clinicians; this request was not granted.3

Unknowingly, this beautiful Hindu woman, a dentist (and therefore with a medical training), reignited the terrible political controversy over the 1992 X case. In that year, a 14 year old girl became pregnant as a consequence of rape and was at first prevented by the then Attorney General from leaving the country with her parents to travel to the UK for a termination, under the so-called pro-life amendment of 1983 which gave equal status to the life of the 'unborn child'.4 A subsequent Supreme Court ruling permitted X to travel on the grounds that her threatened suicide posed a real and substantial threat to her life, as distinct from her health and, under the circumstances of a substantial threat to a woman's life, a medical termination was lawful. The Supreme Court judgment stated that the government must legislate for these circumstances. No government has done so since 1992. In 2011, the European Court of Human Rights in the case A, B, and C v Ireland, ruled that the Irish government had violated C's human rights in

denying her legal access to a termination in Ireland at a time when she was dealing with a diagnosis of cancer. Legislation to bring the government in line with the European Court ruling had not been for thcoming up to the time Ms Halappanavar died, and the findings of an expert group, convened by the current government on this very topic, was delivered to the Minister for Health only days before news of her death was released.

The complex politics surrounding abortion over these twenty years have seen the virtual collapse of the authority of the Irish Catholic hierarchy but a rise internationally of anti-abortion lobbying, much of it associated with and funded by far right groups based in the United States.

In the immediate days after Ms Halappanavar's tragic death, a number of prominent Irish obstetricians, including the current and former Masters of the National Maternity Hospital, stepped forward to state that doctors as a whole needed clarity on the legal position about X. They wanted the government to formally codify the contexts of obstetric clinical judgements made to save a woman's life which necessarily entail a medical termination.[5, 6] As upsetting as these convoluted circumstances are, the shadow of the X case is but one dimension of the troubling events surrounding the maternity services in the same period as Ms Halappanavar's tragic death. Six other maternal deaths from three other units have been publically reported this year, three of these deaths occurring in the five weeks before and after the death in Galway.

An inquest in November, 2012 on one of the deaths returned an open verdict on the woman who was found off the rocks of Howth Head in March, 2012, after being missing since the previous day. She was 38 weeks pregnant with twins and had a history of depression, including depression in her two previous pregnancies. The Master of the Rotunda Hospital, where she had been attending and where she had seen a psychiatrist, told the inquest that their practice for almost two decades has been to hold notes on a patient's mental health separate from antenatal clinical notes for reasons of 'patient confidentiality'. In light of Professor Gwyneth Lewis's work on deaths from psychiatric causes in successive UK national confidential enquiries dating back to 1997, this practice seems bizarre.

The circumstances of each of the maternal deaths this year are different and perhaps very different to the circumstances of Savita Halappanavar's death about which we still know so little. Yet all these deaths have meant unbearable suffering for the women and for their families. At least fourteen children have been left without mothers at year's end. And, because of the aforementioned problems with data recording and data disclosure, even these seven deaths may not be the full picture.

Professor Susan Bewley, who has carried out research on a doubling of the rate of maternal mortality in London's hospitals since 2005, notes that although absolute numbers are still small, maternal deaths are nonetheless 'a sensitive measure' of the quality of maternity services.[7] Pregnancies may well be more complex and women potentially more unwell, but Bewley argues convincingly that maternity services which are understaffed and under pressure may be less able to respond with quality care for women who are ill.[7] And this is the rub in Ireland. All the myth-making about excellent maternity care and outstandingly low rates of mortality cannot obviate the concrete impact of massive cuts. These cuts have

torn services apart since the economic collapse, services that were already poorly thought-through, frequently working outside current evidence, riven with obstetric authoritarianism, and significantly understaffed before that collapse took place.8 What Bewley says about London services, that staff are 'working 'harder and harder to stand still'8 is also the state of play here to the clear detriment of women.

An inquest into Savita Halappanavar's death in Galway will be held later in 2013. There are currently two other official inquiries into her death, neither of which has the support of her husband, Praveen, who has stated he has no confidence in GUH nor in the Irish health authorities to establish the truth of events.

We have a very poor history in respect of other inquiries about serious failures and worse in relation to women's reproductive health: the symphysiotomy scandal affecting hundreds of women over four decades in the mid-twentieth century, the hepatitis C scandal of the 1970s through the early 1990s where women received contaminated blood, the Neary scandal, where over 25 years, scores of women had unnecessary emergency hysterectomies, the scans misdiagnosis scandal of 2010, to name but a few. Almost fouryears after the death of Garda Tania McCabe from haemorrhage and DIC after the birth (and death of one) of her twins by caesarean section in 2007 in Our Lady of Lourdes Hospital Drogheda, and following on a successful civil case against the HSE and the hospital in 2011, both bodies apologised to her widower.

What can an apology possibly mean in such circumstances when people have had to fight so hard to have institutional and official efforts to deny responsibility unmasked and over turned? We want no more worthless, fatuous apologies.

I have written before of how urgently we need the ethic of truth-telling in these circumstances and about our maternity services overall in these troubled times.9 We can hope perhaps for 2013 that more and more midwives will understand the integral logic of this and will speak out on behalf of the women for whom they care. It is that practice of truth-telling that defeats the corrupting effects of silence and the consequences of practices so chaotic and unacceptable as to cost women their lives.

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