Violence in obstetrics

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Beverley Beech reminds us why change is long overdue

In April this year I attended the 23rd annual ENCA meeting in Berlin and presented a paper on Violence in Obstetrics (see my report under What is AIMS up to on page 4). This is an issue that is attracting international attention and shocking stories are emerging from many parts of the world of harsh and cruel treatment.

While we complain about maternity care in the UK, it is, in the main, a great deal better than in almost any other country and we are the envy of much of Europe. That does not mean, however, that there is no violence in obstetrics in this country. It may not be as extreme as the experience of 'Kelly' in the USA, detailed below, but we are not immune from obstetric violence. It usually takes the form of paternalistic coercion rather than physical violence, ranging from bullying women into agreeing to a range of unnecessary or avoidable interventions, surprisingly often backed up by references to threats of a dead baby, to reports to Social Services, if the women do not comply. Most often it consists of disallowing women legitimate decision-making on the grounds that health professionals always know best.

Sheila Kitzinger, as long ago as 1988 wrote that *'Birth in western society has become an institutionalised act of violence against women.'*[1]

The extent of the violence, however, is shocking. A study looking at 65 (mainly qualitative) studies in 34 countries across all geographical and income-level settings found that:

'... physical abuse (slapping or pinching during delivery); sexual abuse; verbal abuse such as harsh or rude language; stigma and discrimination based on age, ethnicity, socioeconomic status, or medical conditions;

'... neglect, poor rapport between the carers and the women; ineffective communications, lack of supportive care and loss of autonomy were widespread.'[2]

One could add to that list the examples of health professionals using threats, or actual reports, to Social Services as a means of control or revenge when the woman decides not to accept professional advice. Increasingly, the AIMS helpline receives enquiries from anxious women who have been threatened in this way.

Other forms of violence include giving partial or loaded information to encourage the woman to agree, such as: '*Your baby could die.*' So common is this tactic that there is a name for it, '*The dead baby card*', and there is even a research paper acknowledging this tactic.[3]

Obstetric violence is not restricted to physical or emotional abuse; it also covers those medical interventions that are carried out routinely, many of which have little or no evidence of benefit: for example, episiotomy, putting women flat on their backs and the majority of caesarean operations.

Female genital mutilation

When this issue is raised many women think of clitoridectomy, the practice in some parts of Africa of mutilating babies and young girls. While the inhabitants of developed nations express horror at such practices they fail to notice that we in developed countries practise a form of genital mutilation all of our own, and we carry it out on adult females. It is called episiotomy. By highlighting episiotomy as a form of genital mutilation I do not in any way wish to diminish the horrors of other types of FGM.

Routine episiotomy was widely used in the USA but it was not adopted in the UK until the 1960s, when its 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 AIMS has examples in the files of women who were given episiotomy after the baby was born because the midwives were afraid of criticism for failing to do one.

As long ago as 2009 a systematic review of the research revealed that 'restrictive episiotomy policies appear to have a number of benefits compared to policies based on routine episiotomy. There is less posterior perineal trauma, less suturing and fewer complications, no difference for most pain measures and severe vaginal or perineal trauma, but there was an increased risk of anterior perineal trauma with restrictive episiotomy.'[4]

The violence of an unwanted episiotomy, however, reached new heights in America in 2014. A woman called 'Kelly', having her first baby, was cut 12 times by her obstetrician after clearly saying NO. She had already told the staff that she had been raped and sodomised twice in her life and wanted them to tell her before doing anything to her body. Her family videoed the assault. Neither the doctor's colleagues nor the hospital took any action when she complained about her treatment. What is just as bad is the reaction of her friends and family; they felt that she should '*get over it*'. She decided to sue for the violation of her right to informed consent and refusal. She could not find a lawyer to take the case, having approached 80 lawyers in California. She finally found one and there are more than half a dozen similar cases, for forced c-sections and other forms of violence during birth, pending in other states. See www.humanrightsinchildbirth.org/kellys-story/ and improvingbirth.org/2015/04/kelly-update/

It appears that American women have no enforceable right to informed consent and refusal during childbirth.

Flat on their backs

At a WHO conference in Brazil in 1985 Professor Roberto Caldeyro Barcia (past president of the International Federation of Gynaecology and Obstetrics) who carried out early research on positions in labour, stated that 'There is only one position worse than laying on your back for the birth, it is hanging by your heels from a chandelier'. When a woman lies on her back the coccyx cannot move, but moving her increases the space in the birth canal by around 3cm. How many babies have ended up being delivered by forceps or ventouse because their mothers were required to birth on their backs? The Care Quality Commission survey found that 'the most common position for women to be in when they gave birth was lying down with legs in stirrups (35%). A further 24% were lying flat or lying supported by pillows. It should be noted that 15% of women had an assisted vaginal delivery, which would normally require stirrups.'[5]

A study of birth position and obstetric anal sphincter damage of 113,000 spontaneous births found that the greatest damage was caused to women who were on their backs. Squatting and a birth seat position involved an increase in risk among parous women.[6] Sadly, the research did not look at women who adopted a handsand- knees position or leaning forward over a birth ball, for example.

How much more research is required before midwives stop pressuring women to birth on their backs?

Caesarean operations

The World Health Organisation has stated that there is 'no health improvement for either mother or baby when caesarean operations exceed 10%.'[7]

In the UK the caesarean rate in many obstetric units is already over 30%, even higher if the woman has private care, and the caesarean rates are increasing throughout the world. If 30% of men in the UK were to have major abdominal surgery, of which two-thirds was avoidable or unnecessary, there would be a national outcry.

Rather than focus on why there are so many avoidable caesarean operations the media focuses on 'the woman's right to choose', or worse, accusing women of being 'too posh to push'. Few informed women 'choose' a caesarean operation; those that do often have had previous trauma and feel that this is the only way they can control what happens to them during the birth, or they are persuaded that a caesarean is the only option. A midwife sat with a woman during a consultation about the options for birthing her breech baby where vigorous persuasion to have a caesarean was applied. When the midwife looked at the notes later, the consultant had written 'woman's choice.'

In 1997 a woman was forced to have a caesarean operation on the grounds that she was at imminent risk of dying. The judge who issued the court order authorising the caesarean was not told that the woman had been confined to a mental health ward where she was not visited by a midwife for two days. She subsequently sued and the judges found that detaining her under the Mental Health Act was unlawful

and so too was the caesarean operation. She was awarded £40,000 damages. The judges stated:*'In our judgement while pregnancy increases the personal responsibilities of a woman it does not diminish her entitlement to decide whether or not to undergo medical treatment*'[8] Fortunately, that view persists today, but it has had little effect on the rising caesarean rates.

Induction of labour

Active management of labour was developed by Kieran O'Driscoll in Ireland as a means of rushing women through the labour ward as fast as possible, (see AIMS Journal Vol:10, No:2, 1998). AIMS campaigned against the routine use of induction and acceleration, and for a time enthusiasm for it appeared to decline. Previously, it was used to speed up 'prolonged labour' but now active management is increasingly used on those women whose pregnancies exceed 40 weeks, and in some areas exceed 37 weeks. Few women are told of the risks or how painful an induced or accelerated labour can be.

The effects on the women

A small study by Hazel Keedle and colleagues in Australia looking at the reasons women choose to birth at home after a caesarean section found that the women were determined that they were never going to repeat their previous experience: *'It's never happening again'; 'treated like a piece of meat'; 'you can smell the fear in the room*'. Their response to having succeeded in a home birth after caesarean were*'I felt like superwoman*' and '*there is just no comparison*'.[9]

Experiences of mistreatment during childbirth have far-reaching consequences for women and communities outside of the direct woman-provider interaction. Prior experiences and perceptions of mistreatment, low expectations of the care provided at facilities, and poor reputations of facilities in the community have eroded many women's trust in the health system and have impacted their decision to deliver in health facilities in the future, particularly in low- and middle-income countries.

Some women may consider childbirth in facilities as a last resort, prioritizing the culturally appropriate and supportive care received from traditional providers in their homes over medical intervention. These women may desire home births where they can deliver in a preferred position, are able to cry out without fear of punishment, receive no surgical intervention, and are not physically restrained.[2] Other women often suffer in silence. They develop postnatal depression or, even worse, post traumatic stress disorder.

As long ago as 1988 Jean Robinson, the President of AIMS, drew attention to a famous essay by Peter Lomas. This is what she wrote:

'When hearing women's accounts I am struck by their sense of powerlessness, and I have often thought of Peter Lomas's famous essay on the effect on a labouring woman's mental state of her dread of envy of those around her.8 When I read his original piece, I was concerned that he described only the mother's perceptions, and did not explore how far the envy she felt in her attendants was real, and whether she might have genuine cause to dread it.'[10,11]

But eighteen years later he wrote:

'Is it possible that a fear of envy is not necessarily a neurotic one or confined to mothers who break down - " but one based on an unhappy reality which causes her to propitiate those around her by making costly sacrifices?'[12]

He describes a syndrome we know only too well - the mystifying apparent passivity of women in the face of mistreatment on the labour ward: *'She does not violently claim her baby when he is taken from her and left to cry in another room.'* His theory fits only too well some of the scenarios women describe to AIMS. Months or years later they are calling us to describe the anguish and anger they could not express at the time.

Sadly, I know of no country in the world that collects mental health data following childbirth. We know from anecdotal accounts that abuse of women in childbirth can result in serious postnatal depression and post traumatic stress.

The latest Confidential Enquiry into Maternal Death[13] found that, of the maternal deaths one in seven, died by suicide, but the statistics could be a lot worse as data is only collected up to a year after the birth. Almost a quarter of the women were known to Social Services, but the report makes no comment about whether the women that Social Services did not know about had deliberately concealed their problems for fear of having their baby removed. In one of the highlighted cases the baby had been removed. We know from our helpline and enquiries that women's fear of Social Services taking their baby is very prevalent.

It really is time that the emotional and psychological impact of poor birth experiences is properly researched, and significant improvements made to the provision and quality of postnatal mental health services.

The effects on the staff

It is now generally recognised in the UK that the current system of large, centralised, obstetric units is dysfunctional and damages both birthing women and the staff who work there. The majority of these units are short staffed and function in an atmosphere of stress, fear and bullying: fear of failing to follow overarching regulations, even when they are not appropriate for the individual woman or baby; fear of failing to keep 'adequate' records so that the staff focus more on the records than the woman; fear of being sued; fear of retribution if the 'rules' are not obeyed.

In The Lancet's 2014 Midwifery series a comment noted that *'discrimination and abuse was linked to, and reinforced by, systemic conditions, such as degrading, disrespectful working conditions and multiple demands'.*[14]

When midwives and doctors work in such conditions it is no wonder that birthing women are mistreated.

When the woman knows her attendant and has developed a relationship with her or him during the pregnancy, the quality of care improves and, as a midwife once commented to me, *'It is much more difficult to be unkind to a woman you have got to know during her antenatal care.*

'

There is now a small mountain of research demonstrating that continuity of midwifery carer has a very powerful effect that enables women to birth normally without the need for a whole range of pharmacological and technological interventions, and it has significant implications for the long-term health of both the mother and the baby.

The rush to force all women to birth in hospital arose without any evidence whatsoever, and no-one asked the women what they wanted. The result is not only damaging to women; it is also damaging to the staff. The time for change is long overdue.

A copy of the ENCA paper upon which this article is based can be found on the AIMS website www.aims.org.uk

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