AIMS For a better birth...

Editorial: Is the 'high risk' label helpful?

AIMS Journal, 2011, Vol 23 No 4

Vicki Williams asks us to question the notion of treating simply on the basis of 'risk'

Reading through the copy for this issue, I have to ask myself, is this label of 'high risk pregnancy' doing women any favours, or is it frequently actually creating damaging additional stress for childbearing women and those who care for them?

It is becoming increasingly clear that, for some women, knowing that they have additional risk factors helps to inform their decisions for pregnancy and birth, but for many others it seems to be a label that creates its own fear and risk purely from the reactions of women and their care teams to it. As the title of this issue suggests, this perception of an increase in risk may serve only to make it more likely that a woman will have unnecessary and unwanted intervention in her pregnancy and birth.

It is important to acknowledge that some women or their babies may have health issues that lead to difficulties, but most labelled as 'high risk' could go on to have completely straightforward births. It is vital that excellent medical care is available for situations when it is needed, as identified in the Confidential Enquiries into maternal and child health; however, until such medical care is actually required, women need to be supported and encouraged to have normal births, with watchful awareness of potential problems, just as should be the case for 'low-risk' women.

This issue of the AIMS Journal has only scratched the surface. It takes a brief look at the concept of safe and undisturbed birth in Sarah Buckely's article, which gives some background on how we can often make birth more risky simply by trying to control it or offer 'help'. Birth in high-income, litigation-driven countries has often become so fraught with danger of our own making that great efforts are made to intervene in order to save women and babies from iatrogenic [caused by medicine] effects. What is needed is a move towards preventing the danger in the first place by providing environments that support undisturbed birth and midwifery care for all women whatever their obstetric status. Currently the medical model focuses on risk, a focus sadly perpetuated by the majority, professionals and laypeople alike.

Just like all mammals, we need to be physically ready for pregnancy. We need to be well nourished and safe during the time we are growing our babies, and we need to feel safe, calm and protected whilst we birth our babies. It is really not hard to achieve, except that we have built a culture of fear round birth which gets in the way of the process and creates extreme danger for us and for our babies during pregnancy, the birth and the bonding period. I have noticed a real disparity between texts which look at

facilitating safe mammalian birth and those which focus purely on human obstetrics. The effects of birth disturbance can create a whole range of problems, including physical damage, disrupted bonding and extreme trauma responses.

A series of articles look at the complex issues around obesity, looking not only at the evidence, sketchy at best, supporting the concept that larger women are always and automatically bound to have complications, but also at how women themselves view the care they receive and the labels that so often go alongside a high weight-to-height ratio. It came as no real surprise to me to see that unbalanced nutrition goes hand in hand as often with obese as with under-weight women, and that both can have serious implications for a growing baby. However, the notion that women can have a high BMI and be well nourished and healthy is one that the current government targets on tackling obesity seem to have neglected to mention.

The issue of meconium is tackled by Sarah Davies. It is something that seems to be feared by birth professionals and women alike, but again the evidence does not seem to suggest any reason for that fear or for the interventions deemed necessary when a baby has opened his bowels before birth. This might be one of those areas where treatment creates many more problems than it prevents; it certainly creates a considerable increase in stress and disturbance.

The selection of birth stories for this issue was very difficult, from the many, many stories we hear of women who have been deemed high risk but have gone on to have beautifully empowering normal births. We chose to share the home birth stories of a breech birth, a twin birth and a post-dates pregnancy. Sadly, with standard care those women may have been encouraged to accept caesarean surgery or induction, but in fact they went on to have births which left them feeling powerful and ready to start their journey to parenthood. All of those parents did a great deal of research into how the risks they were facing applied to them, and they made decisions and gathered their care teams accordingly. Many women simply do not get that chance, for more reasons than we can cover in this journal. Some of these women would have preferred to have the opportunity to birth undisturbed in a hospital setting but were denied that option.

The omissions in the Journal seem glaring. We have not considered VBAC, suspected small or large babies, women with high blood pressure or a diagnosis of gestational diabetes. The list goes on and on and many issues of our Journal could be filled with teasing out the evidence that supports the concept of risk in those situations. However, for unnecessary harms to be avoided we all need to acknowledge that a risk label usually means a shift from a 'tiny risk' to a 'very small risk' of an adverse outcome. That means the chance of everything being normal is still very high. What women want is not a label, but individualised care.