AIMS For a better birth...

Research Roundup

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Effects of social work: information wanted

We are compiling a dossier of cases where expectant or new mothers are exposed to social-work intervention after allegations of child abuse or neglect, and its subsequent effects. We never wanted to spend our time on such cases - we are already much too busy - but the number of desperate mothers appealing for help is increasing, and their stories are so horrifying, we cannot abandon them.

We have never yet seen a case where such intervention was helpful to either the mother or children in the family. On the contrary, we have been astonished at the severity and duration of damage caused. Now that healthcare staff and teachers are expected to act on their suspicions, the numbers of families involved are increasing, and no one knows the ratio of families damaged to children saved from serious harm.

A number of factors worry us:

1. Serious harm can follow even brief interventions, even if no allegations are pursued. It can damage parents' willingness to seek medical care of any kind and their relationships with schools' staff, and the medical and education records of their children - forever - as well as relationships within the family and extended family.
2. Social workers seem totally ignorant of the proven and serious damage to the fetus of increased stress to the mother in pregnancy, which they often cause by increasing mothers' fears that their baby will be taken after birth or that they must jump through invisible, unknown hoops to keep their child. Based on our experience, we can confidently rate this kind of stress as being exceptionally high.

3. Social workers show a woeful ignorance of pregnancy, childbirth, postpartum problems and maternity care.
4. Social workers appear to give too little weight to the wellknown multiple, long-term, adverse effects of the loss of breastmilk on the child, and are far too willing to separate mothers from breastfed children. One such separated child (now returned to its mother, but too late to restore lactation) developed whooping cough in its foster mother's home. The baby was too young to be immunised, yet immunity could have been provided via breastmilk. What if the child had died? There are public enquiries if a child dies because of failure to remove it, but what of the child who dies because of being removed? Enquiries on avoidable deaths of children under social workers' supervision have shown exactly the same mistakes as in cases where children are wrongly removed, or unnecessary care orders are taken out. The difference is that these mistakes - which are much more common - do not reach the public eye.
5. The poor quality of notes and their many inaccuracies make medical records (so often criticised) shine by comparison. Damaging assertions and misconceptions are recorded but, when disproved, there is no appropriate correction or addition made to the file.
6. Mothers with good grounds for needing help and support don't receive it; instead, they are subjected to punitive, authoritarian, stressful investigations that are often aimed at acquiring another baby for the adoption statistics. The only help and support such mothers get is from hard-up voluntary groups like AIMS, while huge amounts of local authority funds are wasted.
7. Many of the personnel involved in sharing information - midwives, health visitors, doctors, nurses, nursery school teachers, teachers and social workers - seem more concerned about covering their own backs than in genuinely listening to, caring about and caring for worried mothers. The emphasis of government policy is wrong and doing infinite harm.
8. Most worrying and sinister of all, some allegations of neglect or abuse come from medical or midwifery staff when mothers have genuine causes for complaint about their maternity or paediatric care. Establishing a quick, fictitious allegation seems to be the latest ploy for silencing them.

We welcome any further information from our readers.

Ultrasound: why so little research?

Yet again, we have written to the Department of Health asking for more research on the possible effects of antenatal ultrasound, especially as mothers are having more scans with much more powerful equipment, making exposure not only more frequent, but more intense as well. We are particularly concerned about the possible risks of increasing Asperger's syndrome/autism, and about the speech and hearing difficulties that mothers are reporting to us.

The ALSPAC study (see p 18) is providing useful information on the long-term effects of various pregnancy risk factors, including ultrasound exposure, in the very large sample of children they are following. All the Medical Research Council - or some other funding body - has to do is provide money for

the analysis. We shall continue to urge them to do so, and to seek funding for further research.

Another worrying group is babies who have had prolonged exposure to ultrasound - an hour or more - because their mothers were persuaded to take part in research on fetal behaviour, which they were assured was harmless (e.g. in Belfast). Some mothers involved in such studies have very damaged children. We have seen no published studies reporting the outcomes of these children vs unexposed controls. Ethics committees should at the very least have required that: a) the mothers were informed of the lack of safety data on results of exposure of this duration; and b) several controls were selected for each pregnant woman in the study so that babies in both groups could be followed.

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Turning the breech baby: what is the outcome?

Women with breech babies are usually offered external cephalic version (ECV) - turning the baby to a head-down position - especially now that most obstetricians routinely deliver breech babies by caesarean section. But what are the chances of a normal vaginal delivery after successful ECV?

Obstetricians in Hong Kong carried out a retrospective study of babies turned during 1995-2000. ECV was successful in 75 per cent of cases. After excluding women with complications such as pre-eclampsia or premature delivery, 279 women remained to be compared with 28,000 controls with normal presentations.

All the women had the 'usual' unit care - induction at 42 weeks for post-term gestation. In 1999, this was changed to routine induction at 41 weeks. All had a 20-minute CTG on admission, and continuous electronic fetal monitoring in the active phase of labour.

The women who had had ECV for breech tended to be older, shorter and more likely to have previous children. The babies were born around 16 days after turning. They were more likely to be induced - 24 vs 13.4 per cent in the controls. Nine women had induction for a suspicious fetal heart trace (CTG): four of these happened immediately after the baby was turned. Four women were induced because of antepartum haemorrhage of unknown origin, three of which occurred within 24 hours of ECV, and the fourth, two weeks later. Five women had labour induced immediately after ECV because of a transverse or an unstable lie - which the authors termed a 'stabilising induction'.

More ECV mothers had labour augmented (50.5 vs 43.7 per cent) and were more epidurals (20.4 vs 12.4 per cent). Only 62.4 per cent had a spontaneous vaginal delivery compared with 77.8 per cent of the controls. The caesarean rate was more than doubled (23.3 vs 9.4 per cent) due to higher rates of failure to progress, fetal distress and failed induction.

Previous authors have reported higher section or induction rates after ECV, but this study showed that the higher induction rate was mainly due to suspicious or abnormal CTGs or antepartum haemorrhage shortly after the baby was turned.

Previous studies have also shown that breech babies who are not turned are more likely to have abnormal CTGs in labour, less favourable acidity of cord blood and low Apgar scores. This suggests that breech babies are less able to cope with the stress of labour.

This latest study shows that, even after ECV, the baby may not do as well as a baby who is spontaneously head down. Measurement of cord blood in babies born after turning has also shown a higher level of stress hormones.

AIMS comments

Mothers feel strongly linked to their babies by the end of pregnancy and it is interesting to put this study in the context of what mothers of breech babies tell us. Many, as we have reported before, are unhappy about ECV, claiming that the baby may be in the position it needs or wants. Their instinct tells them that such manipulation is not a good idea, and is supported by this study. They and other women with unfavourable presentations often object to speeding up labour as a set standard or rigid timetable may not necessarily suit the needs of all mothers - or all babies.

But a word of caution on resisting induction in all cases: it is the baby that triggers labour when it is ready, and that is usually the safest clue to follow if all else is well. But sometimes the pregnancy is prolonged because the baby is not able to do this, as it is known that babies with neurological abnormalities can have prolonged pregnancies. This has to be borne in mind with the breech baby, but it is still not, in our view, an indication for routine induction at 41 weeks - with any baby, breech or otherwise.

However, we do not yet have outcomes for a sizeable-enough sample of babies after different management, and we have to inform mothers on the basis of what information we do have. When mothers are considering their options, outcomes after ECV need to be included and this is the largest such study so far.

Unfortunately, the authors have not included either mortality or Apgar score data. We do not even have such data for babies that had to be delivered rapidly because ECV caused bleeding or fetal heart-rate abnormalities nor, of course, do we have the views of the women on the procedure - still a huge gap in the literature.

References

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Br J Obstet Gynaecol, 2002; 109: 627-31

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Is it harmful to see your dead baby?

A recent study from a team from St George's Hospital in London and the Tavistock Clinic has found that women who saw and held their stillborn babies had poorer psychological outcomes than those who did not. This research therefore challenges the current practice of encouraging women to see and hold their dead babies.

The authors studied 65 pregnant women whose previous pregnancy had ended in stillbirth and who had no other live children. These women were compared with a group of 60 others in their first pregnancy. There was one difference between the two groups-nine of the bereaved women, but none of the controls, had more than one social disadvantage (unemployment, poor housing or low income).

All of the women were rated for depression, anxiety and post-traumatic stress disorder (PTSD) in the last third of pregnancy, and again a year after they had given birth. They also tested the infants for attachment disorder.

The bereaved women were more likely to have depression, anxiety and PTSD during pregnancy than the controls. Their next baby was also less likely to be securely attached when they were one year old.

On analysing the data according to whether the mother had seen or held her stillborn child, the researchers found that women who had not seen the stillborn did best of all, and those who only saw it did better than those who held it.

The authors say that some women were persuaded to hold their child: "I didn't really want to hold him, but they said it would be better for me." They also had the overall impression that most mothers were in shock and simply went along with whatever was expected of them. Some parents who saw and held the baby did not have adverse outcomes, but the authors suggest that some mothers who were already intensely distressed and physically exhausted were further traumatised.

They concluded that parents' wishes on management of a stillbirth should be respected and that there is no justification for telling parents that not seeing their dead baby could make mourning more difficult.

AIMS comments

We welcome this study as it raises important questions. However, it does have flaws. The numbers are small - only 17 women did not see their baby, 14 saw but did not hold it, and 34 both saw and held their stillborn. Although there is a significant trend overall toward an adverse outcome, many of the individual findings are not statistically significant. The small number of controls - 60 - is surprising as it should not

have been difficult to recruit a larger number, and it is now expected that there should be more than one control group in such a study.

This study concentrates on results from standard, well-tested questionnaires. Any qualitative data - for example, the impression that mothers simply went along with what was expected - seem to emerge by accident. Yet, the mothers' experiences and views would be particularly valuable here. The authors mention that the mothers who chose not to see the baby may have been especially confident, but we do not know if those who did not see the baby did so by choice or whether they were just not offered the opportunity. We know nothing of the circumstances in which babies were seen nor how long after the birth, and so on.

One only has to read CESDI reports to see how many stillbirths were avoidable. Many depressed, bereaved parents are suffering not just from grief, but from the trauma of mismanaged births. This certainly contributes to the PTSD cases we see. We find that the level of satisfaction with the care received and how complaints were dealt with are important factors in parents' recovery and resolution of grief. The quality of care, how staff reacts and how they support the mother make a huge difference. Photographs (which can be sensitively or insensitively provided) are not mentioned nor the fact that some mothers who could not cope with seeing the baby in hospital write in long afterwards for a photo.

The authors attribute the change to a policy encouraging mothers to see their babies partly to the work of Lewis in 1976, followed by pressure from women who were "demanding more control over their experience". Since AIMS has been around for 40 years, we can tell them that some women did complain - and most bitterly - that they had never been allowed to see their dead baby, and this was compounded by the fact that there was no burial and no grave in those days. However, when the policy changed, we then received complaints from shocked women that a dead baby was thrust into their arms by embarrassed staff without warning, preparation or consent. Fathers, too, are often unprepared for the experience.

The authors rightly comment that inexperienced staff may feel that the protocol gives them reassurance that there is a right way to manage the situation. We agree, as evidence suggests that some staff manage stillbirth by rote: here is the baby; I have done the right thing; tick, tick, tick... rather than giving true support. But it is not just because of inexperience - sometimes it's because they feel guilty, and with good reason.

References

- Hughes P et al. Assessment of guidelines for good practice in psychosocial care of mothers after stillbirth: a cohort study. Lancet, 2002; 360: 114--8

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Acupuncture reduces need for epidural

A randomised trial of 90 women in Sweden has shown that acupuncture during labour can significantly reduce the need for epidurals and result in women feeling more relaxed.

There is apparently an increasing demand for acupuncture during labour in Sweden, but no prospective trials to show either benefit or lack of harm. The women were asked if they wanted to join the study while pregnant, and were randomised to treatments after they were admitted in labour. Only those with a normal onset of labour at term were accepted, and breeches were excluded.

Care during pregnancy and labour was provided by midwives. The women were offered many forms of pain relief, including TENS, skin injections of sterile water, warm rice bags, baths and showers, Entonox, epidurals, paracervical and pudendal nerve blocks, and bupivacaine.

Acupuncture treatment was given by midwives who had taken a four-day course; the acupuncture treatment was individualised, and used relaxing points as well as analgesic points. The needles were left in for one to three hours, and taped to the skin so that the women could move about.

Labour was augmented with oxytocin in 16 acupuncturetreated and 15 control women.

Of the 46 women in the acupuncture group (all having their second or later child), seven used no other form of pain relief. The most common pain relief used was Entonox, used by 34 women, similar to the number of controls (32 of 44 women). However, epidurals were much less frequent in the acupuncture group - used by 12 of 46 women compared with 50 per cent of the controls (22 of 44). They also used epidurals when more far advanced-when dilated 5.3 cm vs 4.2 cm in controls.

The acupuncture group was also less likely to use nonpharmacological methods of pain relief. Only seven used warm rice bags compared with 23 controls, none used TENS compared with 14 controls, one had a bath compared with seven controls and two had a shower vs nine controls. Drug use was low, with one injection of meperidine in each group.

Most of the women in both groups had a spontaneous delivery. There was one caesarean in each group, and two vacuum extractions in the acupuncture group vs one in the controls. Outcomes for babies were excellent, with no Apgar scores below 7 at one and five minutes in the acupuncture group, and two babies below 7 at one minute in the controls.

There was no difference between pain self-assessment scores between the two groups, so it seems that pain levels were not reduced. The women were assessed on a visual chart every hour. However, the acupuncture group were assessed as being more relaxed, which is likely to make women feel more in control and more able to cope with pain. The authors suggest that further trials need to be done.

AIMS comments

This is a useful study. The authors say that both groups were satisfied with the pain relief they had (though they don't say how they assessed this). In studies of this kind, where all the women are informed of a new treatment that half of them don't get, there can be adverse effects on the 'deprived' group, who may feel disappointed at being allocated to the 'wrong' arm of the trial.

I long to see someone do a three-way comparison in which there is not only a control group having 'normal' care, but a preliiminary observational study of pain relief used by similar women as well. It might then be possible to determine whether the controls chose more rice bags/TENS/baths/showers/epidurals than a comparable group did. Also, were the midwives in the study more anxious to suggest and provide alternative forms of pain relief for the control women?

Nevertheless, the findings look very hopeful, with midwives being able to provide effective treatment after only four days of training. We don't know, of course, whether professional acupuncturists would get better or worse results. As the authors point out, using midwife acupuncturists meant that the women were not disturbed by extra personnel.

How enthusiastic would women be to try acupuncture if they are told that there is no proof that it reduces pain? They may not understand the connection between relaxation and the perception of pain.

Now we only have to wait for the impact - if any - on the UK as this was published in a major British obstetric journal. Midwives are in desperately short supply and, while this is likely to provide a useful addition to the treatment they can provide in the home and midwifery unit as well as in hospital, shall we see the same opposition from management as we have seen to training midwives for waterbirth? Will the anaesthetists be unhappy with the prospect of midwives encroaching on their territory? Watch this space...

References

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The nasty Streptococcus

When newborn babies die of infection, the leading cause is the group B streptococcus. Paediatricians

from Newcastle carried out a survey in the Northern Region in which they looked for risk factors.[1] For each infected baby in a neonatal unit, they selected four controls for comparison. Of 37 such infants, five died. In addition, three stillborn babies were also infected.

Prematurity (less than 34 weeks) was a significant risk factor (as infection can set off early labour). Many of the babies were probably infected in the womb. Both prolonged rupture of membranes (13.5 hours before delivery) and prelabour membrane rupture (26.7 hours before delivery) were risk factors. Nearly 80 per cent - 23 of 29 women - were in hospital long enough before delivery to have been given antibiotics at least four hours beforehand, as recommended by the Public Health Laboratory Service as it has been shown to reduce the chances of high-risk babies getting an infection. Using this policy would mean that 23 of the control women (whose babies were not infected) would also have been treated.

The authors say that current guidelines might prevent or reduce damage in three-quarters of all cases of infection, but with the cost of giving antibiotics to 16 per cent of all women in labour.

AIMS comments

We receive a steady trickle of serious complaints from women who have lost babies who knew they were carriers of group B streptococci from a previous pregnancy, and yet had not had the antibiotic cover they should have had or had asked for. Clearly, practices can be very sloppy. However, we also have many calls from women with ruptured membranes who are reluctant to go into hospital, fearing the greater risk of interference and infection there, including unnecessary vaginal examination. We note that only seven of the 37 women had fever in labour, so absence of fever cannot be taken as absence of infection (though fever in labour was 10 times more common in infected cases than in the controls). What about preventative antibiotic cover at home for those women who want it?

The authors quite rightly raise the question of the increase of antibiotic- resistant germs with overuse of these drugs. And we, too, are concerned that giving women broad-spectrum antibiotics in labour could increase the incidence of necrotising enterocolitis (a serious and often fatal gut disorder) in babies[2].

References

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A possible cause of hypospadias

An increasing number of boys are being born with hypospadias - when the opening that should be at the tip of the penis is situated on the underside of the shaft instead. These boys require plastic surgery to correct the defect.

A recent report shows that such boys are likely to be smaller than controls, with lower weight, shorter length and smaller head circumference.

This information comes from the important ALSPAC (Avon Longitudinal Study of Parents and Children) study following boys born in the Bristol area during 1991-1992 - nearly 8000 children. Of these, there were 51 cases of hypospadias, or 6.4 per 1000, higher than the expected rate of 1-2 per 1000.

Two years ago, an analysis of ALSPAC data showed that boys with hypospadias were more likely to have vegetarian mothers. Now, an analysis of birthweight shows that their weight was 300g less than that of controls, so either the factors causing hypospadias are more likely to retard the baby's growth, or the baby with retarded growth is more susceptible to whatever it is that causes hypospadias.

It is known that birthweight is also lower in males with androgen insensitivity, and the authors suggest that hypospadias may be related to factors that adversely affect the male hormone androgen during the baby's development. Further study is needed to see what the adverse environmental factors might be.

AIMS comments

The increase in hypospadias has caused surprisingly little public comment, yet it is of great concern. The earlier finding that sons of vegetarian mothers are at greater risk is interesting.

References

- Hughes I et al. Reduced birth weight in boys with hypospadias: an index of androgen dysfunction? Arch Dis Child Fetal Neonat Ed, 2002; 87: F150-1

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