'Freedom and choice in childbirth'

Pregnancy is normal

PARENTS' SURVIVAL GUIDE
by MAVIS AIREY

Birth is not just a matter of pushing a baby out of your body. It concerns fundamental human *values* insists a British childbiirth educator, Shiela Kitzinger.

In her most recent book, "Freedom and Choice in Childbirth," she makes a case against the increasing medicalisation of birth which, she feels, not only tends to reduce a pregnant woman to the status of a "uterus on legs," but is inefficient and may even be dangerous.

"Many women today feel as if they have been sucked on to a conveyer belt and are being processed through pregnancy and birth like cars in a highly mechanized automobile plant. They feel guilty when they do anything which holds up the process: asking questions or daring to be persistent in stating what they want.

"The message they receive, even though unspoken, is that they are being 'bad patients,' are naive and selfish, and, if they reveal concern about anything other than safety, that they do not care about their babies," she says.

Yet a woman who is expecting a baby is not ill, she points out.

"Eighty per cent of women have completely normal pregnancies and labours. Twenty per cent are at some special risk. But only half of these are discovered to be at risk durring pregnancy.

"The others' problems are only recognised during labour. So at present the whole system of prenatal care works efficiently for only 10 per cent of women," she maintains.

Though it is often taken for granted that seeing a doctor regularly during pregnancy must be a good thing, and that the more medical care a woman has in pregnancy the better, she says there is very little evidence to support that assumption.

Such factors as lack of education, poor housing, inadequate nutrition, unemployment, and working in a toxic environment can all adversely affect the well-being of the mother and her baby. The kind of care provided today does little or nothing to reduce the impact of social pressures like these, she believes.

"Moreover, in the vast majority of pregnancies the care a woman gives herself, and that which is provided by a partner and other family member, has more significance for her and her baby's well-being than any provided by doctors."

She agrees with the authors of a midwifery textbook who suggest that the label "high risk" ought to be replaced by a different concept — that of "levels of care".

"Some women need more concentrated care than others, or care of a different kind. ... Risk-oriented pre-natal screening often leads to care inappropriate to a woman's needs and harmful interventions such as unneccesary induction of labour."

She warns that any woman who avoids thinking through in advance how she may feel, what she may want to do, and how she wants to be treated as she goes through pregnancy, labour, and birth is likely to be coerced and swept along by *other* people's assumptions about what is appropriate, who then make decisions *for* her.

"Many women who have suffered a labour like that, even one which was straightforward and ostensibly easy, look back on it as an ordeal, not only because of pain, but because they felt trapped, confused, and totally out of control — a phrase which occurs again and again in women's birth accounts."

To avoid this, she advises preparing a birth plan: a concise statement of your wishes for childbirth and the days following birth, worked out beforehand in consultation with your midwife or doctor. One copy is filed with your records, the other you keep yourself.

"It has no formal, binding power, but it gives an opportunity for everyone to understand the things which are most important to you. It should take account of the care you would like if labour is not straightforward, or if there are deviations from the normal ... It is not a blueprint of how labour "ought" to be ... Nor is a birth plan a list of prohibitions to hand to your doctor. It is much more a way of saying, "if such and such occurs, I would like ... "

"Freedom and Choice in Childbirth" by Shiela Kitzinger is published by Viking at $35.

Home and people

Sheila Kitzinger says:

Medicalisation can be dangerous

Medical attitudes:

"A woman's idea of what she wants may be very different from how an obstetrician sees it. She expects time to talk about worries and fears and wants a good deal of information about day-to-day experience of pregnancy, how to care for herself, and how to prepare for labour.

He — for in most cases it is a "he" — is usually primarily concerned with screening for a wide range of deviations from the normal, and, according to how she measures up, placing the woman in categories which determine treatment.

The detection of pathology is an important part of an obstetrician's task. But it should not be the only one. What amounts to the constant ringing of alarm bells in pregnancy can sometimes produce the very abnormalities which obstetricians are trying to avoid. If you lie each day with the threat of raised blood pressure and its dreadful consequences hanging over you, this can actually cause your blood pressure to go up.

Recognition of deviations from the norm is valuable. But an even more important element in the care a pregnant woman receives ought to be support for everything that is going *right*.

Many obstetricians have no idea of how to do this. They are expert at tracking down things that might go wrong, but completely at a loss as to how to preserve and enhance the normal.

Prenatal care, even when it is given conscientiously — and it isn't always — and even when professionals are up to date with knowledge — and they aren't always — can be ineffective, and sometimes dangerous.

Some people think the lesson to be learnt from this is to have still more routine investigations and more sophisticated technology. Others believe there is a great deal to be learned from women themselves, and that what a woman knows about her body and the way in which she can be in touch with her baby inside should form a major theme of care through pregnancy.

Yet medical care usually makes a woman mistrust her own first-hand experience and her awareness of her baby. Her medical records present the sole validated reality."

Midwife's view: doctors take over

"I agree with just about everything in 'Freedom and Choice in Childbirth'," says Karen Guilliland, national chairperson of the midwives section of the New Zealand Nurses' Association, who teaches women's health at Christchurch Polytech.

"In the Western world doctors have taken over birth. In New Zealand the law states that every woman has to be under the supervision of a doctor: to get a midwife, she has to have a doctor as well."

By comparison, access to midwives is freer in the Britain described by Shiela Kitzinger, although Karen Guilliland believes the mid-wife system is under threat there. She says the exception to the

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At the other end of the scale is the United States, she says, where all birth is under obstetric care, and the Caesarian rate is up to 30 per cent in some cases.

She points to the report on New Zealand's maternity services by Roger Rosenblatt, a visiting professor from Washington School of Medicine. He found the small Level 1 maternity hospitals which are under threat of closing have the lowest birthweight-specific perinatal mortality rates, and that most preventable deaths probably occur in the more sophisticated hospitals.

"The possibility must be entertained that something about the environment or quality of care in smaller units is superior to that in more sophisticated centres."

He also found unnecessary referrals may be occurring of women identified as "high risk" without due cause.

"It is right and relevant that doctors deal in abnormal births, but it is important that they don't impinge on the normal — for instance by classing all first babies as 'at risk'," says Karen Guilliland.

"Eighty per cent of births are normal, yet I think birth is a terrifying thing to a lot of doctors. They have been taught it is a medical event and that it's risky.

"Now we have generations of women who also fear birth. Fifty years ago, people expected birth to be a normal process and they expected that they could manage. The modern woman's expectation is that she won't be able to manage without a doctor. It's a vicious cycle."

She is worried, that a lot of high-tech investigations and monitoring are carried out routinely, even though very little research has been done into their long-term effects.

"There is no evidence that routine ultrasound is of any use whatever. There is no research to show routine induction produces a better outcome. Routine giving of ergometrine to contract the uterus is of doubtful value. The routine giving of Vitamin K to all babies at birth is of doubtful value," she maintains.

"There is no research to show what effect pethidine has on a baby in this climate. We don't know if giving the mother oxytocin for induction makes her baby more at risk.

"There is so much doubt involved," she says.

"The more you enable women to feel they are in control of the process, the better the outcome is likely to be," she believes.

"If you know how your body functions, you can make it work for you during birth — it's no longer a fearful thing. Birth is something in major psychological control."

Karen Guilliland says strong consumer input in Canterbury has enabled midwives to offer women a range of choices that is probably better than anywhere else in the country.

A lot of what Shiela Kitzinger suggests in her birth plans now happens in Canterbury, especially in some units, she says. "The rates of pethidine administration have plummeted. Support systems are encouraged. Active birth is quite common."

Nevertheless, she feels making out a birth plan is a useful way of thinking through what you feel about birth, particularly coming to terms with the possibility that everything may not be normal.

One woman's support group.

Sheila Kitzinger advises a pregnant woman to develop post-birth strategies well before her baby is born.

Social pressures shape choices

"Even when we feel most freedom to make choices, those choices are restricted and shaped by social pressures. New choices close the doors on others.

"When we get the choice of controlling the number of children we bear by using contraception, in effect we lose the choice to have very large families, and women who do so — at least if they are poor — are labelled social deviants and problem cases. As a technology develops which gives us the choice to screen for imperfections in the foetus, and to abort a foetus which is not up to standard, increasingly women lose the choice to bear handicapped babies.

When the choice of having complete anaesthetic pain relief in childbirth is available, pressure is put on women to agree to its use and they lose the choice of labouring without drugs. When all women can choose to give birth in hospital it becomes more and more difficult to make the choice, and to get others to agree to it, to give birth at home.

"Choice is not just an individual matter, to do with personal and private decisions. It always takes place in a social context, and it is important that we are aware of the constant pressures on us which define and limit the choices

No one right way to have a baby

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Yet a woman who is expecting a baby is not ill, she points out.

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"If you know how your body functions, you can make it work for you during birth — it's no longer a fearful thing. Birth is something in education, poor housing, inadequate nutrition, unemployment, and working in a toxic environment can all adversely affect the well-being of the mother and her baby. The kind of care provided today does little or nothing to reduce the impact of social pressures like these, she believes.

"Moreover, in the vast majority of pregnancies the care a woman gives woman's needs and harmful interventions such as unneccesary induction of labour."

She warns that any woman who avoids thinking through in advance how she may feel, what she may want to do, and how she wants to be treated as she goes through pregnancy, labour, and birth is likely to be coerced and swept along by *other* people's making out a birth plan is a useful way of thinking through what you feel about birth, particularly coming to terms with the possibility that everything may not be normal.

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When tests are performed the woman is rarely asked what she knows, and what she says is usually ignored.

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Though many hospitals still rely on hormone tests or urine or blood to discover if the placenta is working properly in late pregnancy, when mothers themselves keep kick charts (of foetal movements) they are often more accurate in predicting problems than any chemical tests.

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Problems in high-tech care

"Technology has enabled doctors to introduce a whole range of new screening tests into prenatal care. But these have produced new problems. One is that of the *false positive* diagnosis, and the unnecessary intervention that often takes place because of it.

Doctors, on the whole, do not worry so much about false positives as false negatives. They prefer to err on the side of over-diagnosis . . . yet the consequence of a false positive diagnosis can be catastrophic for the woman — unnecessary hospitalisation, induction of labour and Caesarian section, for instance — and a baby born before it is ready, exposed to the dangers of prematurity.

Care givers, often with the best will in the world, use their authority to indoctrinate the pregnant woman with the idea that she should passively undergo any and every investigation — however stressful to her — for the sake of her baby.

Amniocentesis is only the first of a whole range of tests and operations that can be done inside the body of the mother. They all raise enormous moral questions about abortion, and about the quality of life, a woman's rights over her own body compared with her responsibility to the foetus, and her personal rights compared with her responsibility to society."