Doing no harm at birth

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The recent release of the Qld 1999 perinatal ("around birth") statistics is encouraging for Aboriginal mothers. Figures show a significant drop in the chance of indigenous babies dying around the time of birth, compared to 1998 figures (CM 31/12/01). Unfortunately there is no good news for the rest of us.

These data show that women giving birth in Queensland are subjected to some of the highest rates of intervention in the world. For example our 1999 caesarean rate of 23.9% eclipses the US 1999 rate of 22%. Both figures are the highest on record. The World Health Organisation states that "There is no justification for any region to have a rate higher than 10 to 15%".

Exactly one-quarter of birthing women had their labour induced in 1999, and another quarter were administered the same synthetic hormone to augment, or speed up, their labour. These are also well above US rates (19.8 and 17.9% respectively). Again, WHO recommends that "No region should have rates of induced labour higher than 10%."

Rates of forceps and vacuum deliveries remained about static, but added to the rising caesarean rate, mean that around one-third babies were surgically removed in Queensland in 1999.

This 'operative birth rate' (forceps, vacuum plus caesarean) has always been significantly higher for women giving birth in private facilities, (eg 46% in 1996). However such analysis has been deleted from the public record in recent years.

As well as these procedures, over 80% of Queensland mothers and babies in 1999 were exposed to at least one of the strong pain-killing drugs used in labour. For example more than half of labouring women used nitrous oxide gas, around one-third used narcotics (eg pethidine) and one third used epidural pain relief.

For the small minority of women who need help in pregnancy and birth, obstetric assistance is most welcome and can even be life saving. However the widespread use of obstetric technology, as indicated by these figures, has not been shown to benefit the vast majority of mothers and babies. There is also an increasing amount of research showing that these interventions can carry their own risks.

For example, known detrimental effects of caesarean surgery include an increased risk of death for the mother. Recent Australian research concludes that the risk of dying in childbirth, solely from having a caesarean, is around one in 37,500. In these figures, which include all 100 maternal deaths in Australia from 1994-6, the deaths of 4 mothers were directly related to the operation.

Caesarean surgery also carries increased risks for the mother in her next pregnancy. These include ectopic pregnancy, uterine rupture and catastrophic bleeding at birth due to a low-lying, separated or 'morbidly adherent' placenta. All of these conditions can threaten the health, and life, of the baby.

Research into the longer-term effects of obstetric interventions is sadly lacking. The small number of studies published so far (including recent research into ultrasound) raise the possibility that exposing babies at this very vulnerable stage of brain development may lead to subtle abnormalities in brain function. Some studies have linked exposure to drugs and procedures at birth with an increased risk of drug addiction and of anti-social behaviour in later life.

As a GP, writer and mother of 4 naturally born children, I wonder why we have come to accept the current scale of intervention, with such pain, trouble expense and risks for all involved. The truth is, for 80-90% of women, giving birth could be drug-free, exhilarating and empowering - this is nature's intent.

During labour, both mother and baby produce hormones - the body's chemical messengers - which peak at birth. They include the hormones of love (oxytocin), pleasure (endorphins), excitement (adrenaline and noradrenaline) and mothering (prolactin). These hormones orchestrate the processes of birth, enhancing safety and ease for mother and baby. They also help with intuitive mothering behaviours and reward us with ecstasy as our baby is born, making us want to give birth again and again.

This is not to imply that a natural birth is painless. Giving birth is a huge event, emotionally and physically, and will make demands on the body equivalent to, for example, running a marathon. But when a woman is confident in her body and well supported, the pain becomes just one part of the process, and something that she can respond to with breath, sound and movement.

In Queensland today, very few women have - or are allowed to have - this deeply satisfying experience, which can only unfold when the natural process of birth is not disturbed. In one Australian study only 4% of women gave birth without drugs or interventions.

Women are still being told that natural birth is unsafe. Yet there is an irrefutable body of scientific research that shows that natural birth, and the models of care that support it, (birth centre, homebirth, midwifery care) are very safe and satisfying, as well as having enviably low rates of intervention. (eg caesarean rates below 5% in many studies)

The research evidence alone should be enough to convince policy-makers, but, added to this, there are also significant cost savings when low-tech models of care are used in childbirth.

How ironic it is, then, that the state government has recently spent thousands of dollars pursuing a Queensland birth attendant whose records of safety and non-intervention are among the best in the world, and who has clients queuing because her service is so unique. Apart from seeking to stop her practice, the state has made no positive moves in support of the types of care that are so obviously needed.

For example, 0.6% of Queensland women gave birth in a birth centre in 1998 (1999 figure is inexplicably confidential). Research in other states suggests that around 20% would prefer to have their baby in a birth centre.

International researchers suggest that homebirth should be offered to all low-risk women because of its safety and low-intervention rates, yet only 0.3% of births in Queensland in 1999 were documented as planned homebirths. In all of these cases, homebirthing families bore the entire cost (around $2000). In other states, women have been able to access free midwifery care for home and/or hospital births.

In neighbouring New Zealand, women are able to choose their own midwife, who will care for them in pregnancy, birth and afterwards whether they give birth at home or in hospital. In the 10 or so years that this model of care has been available, death rates for babies born in NZ have reached an all-time low. This service is completely free to families.

It is my hope that Queensland women will come to realise how woefully inadequate our current childbirth services are, and to understand that government policies are directly determining, and limiting, our choices and experiences in birth. This is why we have ended up with the over-medicalisation of birth that the above figures reflect. This model of care has not been endorsed by the women using it, nor has it been subjected to public scrutiny and debate.

I hope also that Ministers and policy makers will wake up to the benefits of low-technology models of care. We need support at every level for those models that exist, and we also need an expansion of this philosophy, so that all women can have this choice within the state-funded system.

To paraphrase Dutch Professor of obstetrics, G Kloosterman, natural childbearing in a healthy woman is so exquisitely orchestrated and perfectly attuned that it cannot be improved upon. The task of carers and attendants- and politicians, I would add - is to follow the first principle of medicine - nil nocere - do no harm.