Has Medicalisation Of Childbirth Gone Too Far?
Author(s): William Camann, Meh-Noi Lim, Stephen Ong and Peter S. Yeh
Published by: BMJ Publishing Group
Stable URL: http://www.jstor.org/stable/25451822
Accessed: 11/12/2013 20:31

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patients certainly did not have new variant Creutzfeldt-Jakob disease. Perhaps we should drop the "C" from Creutzfeldt-Jakob disease.

Michaela Reuber | specialist registrar
Department of Neurology, Leeds Teaching Hospital
NHS Trust, Leeds LS9 7TF
mreuber@doctors.org.uk

1 Venters GA. New variant Creutzfeldt-Jakob disease: the epidemic that never was. BMJ 2001;323:858-61.
2 Venet W. Should young UK cattle be considered free of BSE or is it endemic? Br Food J 2001;103:284-90.
3 McLean CA, Ironside JW, Alpers MD, Brown PW, Cervena-

Possibility of BSE being cause of variant CJD is indeed biologically plausible

Editor—Venters argued against bovine spongiform encephalopathy (BSE) causing variant Creutzfeldt-Jakob disease. In fact, the biological plausibility of this being the cause, the strength of the epidemiological association, and the experiments indicating that the same problem is involved are all good.

Incubation periods for BSE are proportional to the life expectancy of the animal affected. The disease's incubation period is 18% of a cow's life expectancy and would be expected to about double when crossing to another species—that is, to 36% of 70 years in humans. Thus the incidence of a disease due to BSE in humans would be predicted to peak in 2014. A few human cases would be seen before 2000 and none early in the 1990s. Small outbreaks would be expected early in the epidemic before they become lost among a high background prevalence. The pattern of variant Creutzfeldt-Jakob dis-

case fits this. In the United Kingdom has eaten on average over 50 meals of the tissues of cattle infected with BSE; this figure would be higher in other countries. The novelty of variant Creutzfeldt-Jakob disease is not now questioned as it is different from kuru on histopathological grounds and scrapie prion (PrPsc) biochemistry. No similar cases before 1995 have been found.

BSE infects a different range of animals from scrapie and infected all the species inoculated experimentally except chicke

Author has overlooked several findings that support his argument

Editor—Venters's reappraisal of variant Creutzfeldt-Jakob disease (vCJD) is impor-

Finally, BSE began in dairy herds in 1986, almost immediately after the Ministry of Agricul-
ture, Fisheries and Food removed controls on foodstuffs for cattle and mandated supplementary feeding with proteinaceous offal, often containing scrapie material, to increase milk production.

Secondly, suckler-fed, grass-fed pedigree herds were virtually unaffected unless they were in contact with dairy cattle.

Thirdly, BSE subsided when supplementary feeding with proteinaceous offal was banned.

Fourthly, ascertainment of unprecedented intensity has shown an excess of all five forms of Creutzfeldt-Jakob disease in the United Kingdom since 1989 but no excess of variant Creutzfeldt-Jakob disease in those at high, controlling, and percutaneous risk of occupational exposure to BSE—namely, veterinarians, and people working on farms and in cattle markets, abattoirs, butchers' shops, and can teers.

Fifthly, the same ascertainment has identified variant Creutzfeldt-Jakob disease in younger people with questionable levels of presumed exposure from ingestion of cooked beef or beef products possibly containing BSE. An epidemic incidence, from 0.8 confirmed cases per mil-

Has medicalisation of childhood gone too far?

Regional anaesthesia in labour permits childbirth without fear

Editor—Several points in Johanson et al's review on the medicalisation of childbirth deserve comment. Firstly, maternal mor-

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Letters

Tality related to anaesthesia has declined dramatically over the past few decades. Recent surveys from both the United Kingdom and the United States find that the few (fewer than 1% in the UK) complications of anaesthesia in obstetrics are usually related to complications of general anaesthesia—for example, loss of airway or hypoxia.1

The decline in the use of general anaesthesia for caesarean delivery must partly be attributed to the earlier use of regional analgesia during labour.2 In fact, the American College of Obstetricians and Gynecologists has issued a statement saying: "Failed intubation and pulmonary aspiration of gastric contents continue to be leading causes of maternal morbidity and mortality from anaesthesia. The risk of these complications can be reduced by careful antepartum assessment to identify patients at risk, and appropriate selection and preparation of patients who require general anaesthesia for delivery."3

Johnson et al's paper states that women are "encouraged" to receive epidural analgesia in labour. This paternalistic attitude ignores the fact that most women in labour choose epidural analgesia of their own volition, without influence. I believe firmly that the choice for women to elect to undergo natural childbirth should always be available (within the limits of safety with regard to certain maternal risk conditions), as long as some of us choose to climb mountains or run marathons. This should also be accompanied by the attitude among all obstetric and anaesthetic care providers that there is nothing "wrong" with women who choose natural childbirth.

But most people do not run marathons or climb mountains. And most women do not want to have pain during childbirth. The widespread use of regional analgesia in labour should be considered as one of the blessings of having a baby in this millennium. Pain-free childbirth has become as much a part of modern culture as the mobile phone or the microwave oven.

Johnson et al state that "childbirth without fear should become a reality for women, midwives, and obstetricians." As one of the cardinal fears of labour is pain, the widespread availability and use of regional analgesia should go a long way towards reducing this fear.

William Camann director of obstetric anesthesia Brigham and Women's Hospital, Harvard Medical School, Boston, MA 02115, USA wcamann@partners.org

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Timely intervention is the key

Estor—Johanson et al imply that medicalisation of childbirth has led to a high caesarean section rate and quote data from Catalonia to Ontario.4 They have forgotten their neighbour, the Republic of Ireland, where active management of labour is practised in some units.5 The National Maternity Hospital in Dublin, for instance, boasts a section rate that has been consistently among the lowest in developed nations.

Strict criteria for the diagnosis of labour, early amniotomy, use of oxytocin, and the involvement of a senior obstetrician at an early stage are cornerstones of the active management of labour. In addition, units in Dublin believe strongly in patient choice, and epidural analgesia is widely used. Do Johanson et al not consider these interventions to be medicalisation?

Active management of labour was designed primarily to reduce morbidity (and mortality) associated with prolonged labour—something that most obstetricians of the present generation seem to have forgotten about. One of the side effects of the active management of labour is a reduction in the caesarean section rate.

Surely the authors must accept that some of the reasons why the United Kingdom has a high section rate has to do with the fact that we don't know how to diagnose labour (ask any midwife or obstetrician and you will get a myriad of responses) and we don't know when to perform an amniotomy, use oxytocin, or involve a senior obstetrician.

No, the problem isn't that the medicalisation of childbirth has gone too far; rather, it's that we don't know when to intervene. We agree with the authors that visits to other units and countries should be encouraged. More of us should travel across the Irish Sea.

Meh-Boi Lim senior house officer in obstetrics and gynaecology Walsgrave Hospital, Coventry CV2 2DX mehhoi@hotmail.com

Stephan Ong clinical research fellow Nottingham City Hospital, Nottingham NG5 9PB


Pregnant women at term with rupture of membranes before labour are subjected to routine induction of labour. Again, the paternalistic approach offers no choice. Expectant management for even the next 12-24 hours is perceived as too risky an alternative. Even pregnant women at 36 weeks' gestation are subjected to the same routine protocol.

All women in labour undergo routine midline episiotomy. Every woman is subjected to this regardless of gestation (term or preterm). The episiotomy rate approaches 100%

The above practices are so entrenched that any change of practice would meet much resistance. Increasing medicalisation has led not to diminishing but to increasing numbers of medico-legal cases. A vicious cycle ensues. Obstetricians now act and intervene even more for fear of litigation.

Government health statistics show that the number of registered midwives declined in the past decade, from 1891 in 1990 to a mere 558 in 2000. During the same period the number of registered doctors rose from 19 921 in 1990 to 21 065 in 2000. This is for a population of 20 million in 1990 and 22 million in 2000.6

As Taiwan now seeks observer status in the World Health Organization, professional bodies and governments in Taiwan should promote obstetric practice as contained in the WHO report Care in Normal Birth: A Practical Guide, which aims at improving obstetric practice in normal childbirth.7

Peter S Yeh senior resident in obstetrics and gynaecology
Taiwan Adventist Hospital, Taipei 105, Taiwan yehpeter@hotmail.com

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Evolving general practice consultation in Britain

Increasing consultation time may not be straightforward

Estrup—Freeman et al plead for more consultations in British general practice.8 A pilot study performed with six general practitioners in Glasgow shows that breaking the habit of short consultations may be difficult and longer consultations may lead to higher health service costs.

Our study piloted a randomised controlled trial of the effect of an increased booking interval on identification of the patient's psychological distress.9 Each doctor's surgery was randomised to either 10 minutes per patient (the normal booking interval) or 15 minutes. One of us (MS) offered locum sessions to make up the shortfall in available consultations. We recorded 65 consultations at each booking interval for each practitioner. The consultation, patient-