



Pregnant in An Age of Compliance

The myths of medical technology and power

A DISCUSSION PAPER FROM THE CENTRE FOR WELFARE REFORM

Maria Lyons

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Summary

In an article provocatively titled *Why most published research findings are false* John Ioannidis states that “for many current scientific fields, claimed research findings may often be simply accurate measures of the prevailing bias”. In a time when an appeal to “the science” is increasingly replacing more traditional forms of decision-making, the implications of this statement are extremely concerning. Nowhere more concerning than in the field of healthcare, where history has shown time and again what can happen when the “prevailing bias” becomes so powerful it takes on the status of absolute truth. Not only does it create an environment which is antithetical to science itself, in the true sense of the term, it can have catastrophic consequences in clinical practice. Focusing on reproductive health and technologies, this paper describes some of the harmful practices which resulted from allowing the “prevailing bias” to suppress emerging empirical evidence. It suggests that we have not learned valuable lessons from the past. Moreover, this paper argues that where one version of ostensibly scientific truth reigns supreme, it is not only competing scientific viewpoints that are denied validity as a basis for decision-making, but all other categories of human experience. Drawing on both personal experience and research, this paper attempts to illustrate how this uncompromising status quo has led to a health system in which the principle of informed consent is routinely undermined, in which questionable tactics are adopted to encourage compliance with its care regimes, and in which personal choice is increasingly restricted. It concludes that the response to this presents us with fundamental questions about what we hold most dear, both as individuals and as a society. For it cannot be stated often enough that in a world with no personal responsibility there are also no rights and in a world without risk there is also no freedom.

Ioannidis JPA (2005) *Why most published research findings are false*. PLoS Med 2(8): e124

I. Introduction

So much of what is nowadays termed healthcare has far more to do with the subtle manipulation of behaviour and fostering of compliance than it does either health or care. Of course, with the ‘coronavirus crisis’ the gloves have come well and truly off. We have shifted, almost overnight, from a state of being nudged, cajoled and at times frightened into certain ‘health’ behaviours to a state of police enforcement of certain ‘health’ behaviours.

Pregnant women are particularly vulnerable to manipulation because they have suddenly become entirely responsible for another life. Now we have all been rendered responsible for each other’s lives, in the most negative of ways. Where the medical interference with her body and public censorship of a pregnant woman’s conduct (I have been denied a back massage, tut-tutted in the sauna and told off for eating a certain type of cheese) is legitimised by a claimed concern for the wellbeing of the foetus, now we are all compelled to follow the rules (we cannot travel, we cannot gather in groups, we must wear face coverings and so on) in the name of the public good. The interference, once restricted, is now universal and the right to disagree with medical advice has been removed.

Given that we are in a new reality where much of this is now widely discussed, I have asked myself whether it is still worth sharing my story. I have decided it is still worth it for two reasons. The first is that I believe it is important to expose the mythologies that validate the ever-increasing medicalisation of pregnancy and childbirth. Although women’s empowerment is as illusory in this realm as in most other areas of modern life, it needn’t be. I can offer many examples of how compliance is encouraged by an appeal to the emotions of fear and guilt. These emotions are provoked when the risks of not following standard practice are emphasised at the same time as the potential harms caused by standard practice itself are downplayed or ignored. The exaggeration of risk – and conversely, a false impression of safety – is achieved primarily through the way that information is presented, or withheld. Arming ourselves with facts thus remains, at least in some areas of healthcare, a way to empower ourselves.

My second reason for writing this paper is because it feels, in some small way, like an act of resistance in the context of increasingly authoritarian – not to mention absurd – public health politics. At the time of writing, in Scotland, it is still my decision whether to undergo certain tests and screenings while pregnant and I can choose how to act on the results. I am

still able to refuse vaccinations for myself and my unborn baby. My consent is still required for all medical procedures. Ultimately, I am still entitled to make my own assessment of ‘risk’ versus ‘benefit’, however difficult that may be. Yet, the precedents set during the coronavirus pandemic mean that none of this may be true for much longer. Will my children look at me one day and ask how my generation could have let this happen? If they were to hold me responsible, they would be right.

Pregnancy is in a sense a loss of individuality, a transformation that happens as another life becomes wholly fused with and at the same time more important than one's own. Who we have been up to this point becomes secondary as we are re-christened ‘mum’. To a certain extent this is natural and positive. Motherhood is the most profound experience of selflessness. But with the overwhelming urge to protect and nurture comes a particular vulnerability and today this vulnerability is exploited in a very particular way. Culturally it is as if a woman's body becomes public property as soon as she conceives. The ‘embryo’, the ‘foetus’ and then the ‘baby’ is almost at once perceived as a separate entity from her, and this creature seems not only “unconnected with the woman who carries it” but has apparently separate interests. In her book on reproductive technologies Patricia Spallone describes how the predominantly male-centred, scientific view of birth and reproduction sees woman:

“in the role of a life-support system, not women as acting with nature in a conscious, human way during pregnancy and childbirth”.¹

My own experiences during two pregnancies certainly exemplify this. At my first visit with the midwife after conceiving my son I indicated my desire to have, as far as possible, an intervention-free birth. The midwife's response was, and I quote:

“you may be allowed to try for a vaginal delivery”.

This statement alone sums up so much of what I hope to convey here:

- How pregnancy is viewed as a medical condition
- How expectant women are managed rather than cared for, and
- How the whole approach is characterised by a deep mistrust of nature, a disregard for women's direct bodily experience and an over-reliance on technology.

Choice, although heavily idealised in this world is, in reality, severely restricted. Beyond that, my interactions with the health system also illustrate ways in which blind faith is ever-present in our science-obsessed society. I wanted to explore why this is the case, not simply to rail against healthcare institutions that undermine individual autonomy at every turn but to understand our own compliance, hence complicity, in sustaining these institutions. Instead of astonishment, indignation, even anger in the face of such obvious paternalism, the reaction of my contemporaries – a whole generation of ‘liberated’ women – is simply acceptance. To regain some measure of autonomy, to move toward freedom, is to own, rather than forfeit responsibility for, our health, our bodies, our lives and the lives of our children.

2. Choice and Perceptions of Risk

When I became pregnant for the first time, it was like the doors opened on a whole new world, one with its own rules, expectations and rites of passage. In many ways, becoming part of this world is very exciting; you are treated in a completely new way, you feel privileged, it is like belonging to an exclusive club for a brief but intense period. Although for me the state of being pregnant was indescribably joyful, much of what I can only call the procedure surrounding pregnancy quickly turned sour.

From the moment you are entered into the system at your “booking appointment” you begin a schedule of checks, tests, screenings and prescribed immunisations that is universal and entirely impersonal. Although midwifery guidelines emphasise the importance of forging relationships, continuity of care and the primacy of women’s right to choose, in practice there is no time for all that once the seemingly endless paperwork (or data entry) has been completed.

To be sure there are differences for different medical histories, but these are set within a framework of “pathways” and in Scotland, where I live, you are assigned the “green”, “amber” or “red” care plan according to certain externally defined facts about yourself. As I quickly learned, any questioning of one’s allotted pathway makes care providers distinctly uncomfortable, and deviating from it is made very difficult indeed.²

It is interesting to see how in antenatal care, as is likely the case in other branches of healthcare, the risks associated with nature and the possible ‘malfunctions’ of the human body are well-defined and clearly presented, whereas the potential for iatrogenic harm (illnesses caused by medical examination or treatment) goes unacknowledged.

When I decided to opt out of the routine 12 week ultrasound scan, for reasons I will come to, the midwife was extremely disconcerted. Not, I believe, because of any real notion of danger for myself or my unborn baby but because it was a “departure from the care pathway”. Upon asking why she was urging me so strongly to have the scan, she merely re-iterated that it was normal procedure. I told her I was not anxious about my baby’s wellbeing at this point, and she replied that my refusal of the scan made her anxious. In the end my straightforward “no thank you” landed me in a room with a junior doctor who promptly summoned the obstetric consultant in charge who in turn ushered in a third un-introduced person, presumably a student brought in for a lesson on how to deal with a ‘challenging patient’.³

Reflecting later on the obvious consternation I had caused, it dawned on me how many of the protocols are designed for the professional’s reassurance, not for mine.

I can only speculate as to the reasons for their nervousness but I have no doubt as to the effect it has on the state of mind and self-confidence of pregnant women.⁴ Anxiety is infectious and intentionally or not, constant checking, testing and monitoring only adds to the general impression of imminent danger, that being with child is a pathological condition.

“How did obstetric science come to the extraordinary conclusion that no birth is normal except in retrospect?”⁵

For obstetricians intervention is the norm but gradually the meaning of ‘normal’ is shifting as more and more pregnancies are categorised ‘high risk’ and brought within their purview. The extent to which natural processes are mistrusted is seen in the ever-more stringent conditions a woman must meet in order for her to be “allowed” to proceed intervention (artificial induction and/or caesarean) free.⁶

The feeling that I existed in a different paradigm to the medical staff was re-enforced when a (male) doctor called me ‘brave’ for wanting to let my thus far uncomplicated pregnancy continue to full term. I suspect what he meant was ‘foolish’, but he was too professional to say so.

It was only towards the end of my second pregnancy that I fully grasped how much my freedom of choice was restricted within this paradigm. My first delivery had been a frantic, frightening and utterly demoralising experience (up until the actual birth, after which, for a time at least, none of it matters) resulting in an emergency caesarean. Therefore, the second time round I longed to have my baby in the peaceful, unthreatening intimacy of my own home accompanied by midwives who had witnessed, and thus did believe in, the potential for ‘natural’ birth.

Great efforts were made to discourage me from this course of action, the reason being that vaginal birth after a previous caesarean section (VBAC) has an increased risk of uterine rupture. This is a potentially serious, but extremely rare, condition, estimated at less than 1% of VBACs. While acknowledging the validity and sincerity of their concern, this was a level of risk I was prepared to accept, particularly when weighed against the risks of a hospital birth. When it became clear that neither statistics nor stories would deter me, I was informed that I could stay at home but that the midwives attending would be on high alert. If there were any unfavourable indications an ambulance would be called. In other words, my labour would have to be text-book perfect. Needless to say, the pressure created by this benchmark would defeat the point of a homebirth. I agreed to a hospital birth because, frankly, I felt outmanoeuvred.⁷

3. Fostering Compliance

No one has the power to fully control the timing, manner or outcomes of childbirth, however managed the process may be. Birth planning is another matter however and the above shows how we might be given the impression of choice while decisions are effectively taken out of our hands.

This was one time I was in fact out of options but there were many other ‘softer’ techniques used in attempts to influence my behaviour, all of them utilising more or less directly the emotion of fear. I do not mean that health professionals deliberately exaggerate risk in order to make people fearful; but that they themselves operate from a place of fear and pass that on by sharing its source, often packaged in glossy little booklets which guide the reader to the preferred course of action. I cannot count the number of times I have discovered the information in these leaflets to be biased, misleading or plain wrong.

If you want an apprehensive first-time-mum-to-be in her 40th week of gestation to ‘opt for’ an artificial induction of labour, a good way to do it is to repeat the word ‘stillbirth’ at every opportunity. When I reached 40 weeks during my first pregnancy I was issued with a sheet of paper informing me of a small increase in the risk of stillbirth should I continue to wait for spontaneous labour.

This fact sheet came without a similar fact sheet on the risks of induction; and there was no indication that the studies quoted were both out-dated and controversial, which I later discovered to be the case. At every appointment thereafter – and there were many because I waited a further two weeks – the first topic of discussion was always the chance of stillbirth, not the much greater probability that my baby would be fine. In my view medical staff have a duty to inform patients of risks, in so far as they are aware of them, but there is the respectful, balanced provision of information and then there is psychological pressure.

I did not keep the handout, but I am reasonably certain that the risks of stillbirth were presented to me in relative, rather than absolute, terms.⁸ Another way that statistics can be misleading is when population-based risks are given without acknowledging individual mitigating factors.

For example, in the hospital I was encouraged to consent to my one-day-old daughter being given a tuberculosis vaccination because there had been a recent “outbreak” in London where we were at the time. On looking into it I learned that the figures were relatively low and predominantly confined to individuals born abroad, living in poor housing, with poor nutrition and or chronic illnesses. I am no statistician but I judged that the chances of my

healthy, exclusively breastfed, home cared-for baby living in affluent West London being exposed to and contracting the disease were again, not high and consequently a level of risk I was willing to accept. Interestingly, the jab was not mentioned to me at any time before my delivery. I was fortunate enough to have some prior knowledge, but what parent of a newborn in all the shock and vulnerability of the circumstances will have the opportunity to conduct research before signing the dotted line? Without being given a full picture, and time to consider, can the consent obtained from parents really be called ‘informed’?

At other times information I received was simply inaccurate. At one meeting with my midwife and her midwifery student I admitted to drinking the occasional half-glass of wine with my dinner. I was immediately instructed, in the strongest of terms, to abstain completely because new research had demonstrated that even a single glass of wine could result in foetal alcohol syndrome. I found this unlikely so I asked for the reference to this research. It turned out the study was about the effects of binge drinking, that is, it showed that consuming four or more units of alcohol in one sitting was associated with later mental health problems.

While I agree it is probably right to err on the side of caution, here was a midwifery student, fully endorsed by her mentor, blithely misquoting her own literature. What they say, and how they say it, matters because the individuals on the receiving end are already easily distressed, for good reason. I can only imagine the horror I would have felt if I had simply accepted this statement as true, what tests I would willingly have undergone to ease my anxiety that I had somehow damaged my baby.

Finally, when an appeal to what appears to be evidence fails to achieve the desired result, there is always the option of straightforward scare tactics. When I declined the influenza vaccine, which is routinely offered to pregnant women in the winter months, I was told an anecdote about a previous patient admitted to hospital with respiratory distress. This was not the only time that an uncommon event was described to me in such a way as to give the impression it was a fairly common occurrence. Moreover, at no time were the “uncertainties that still exist” regarding both the effectiveness and safety of the vaccine communicated to me.⁹

Again, I am sure my midwives were acting out of genuine concern for my wellbeing and their efforts to get me to comply with public health policy made absolute sense in the context of their training and belief system. It is this belief system which is, however, a major part of the problem.

4. Evidence or Faith Based Healthcare?

Once during the early stages of pregnancy I was advised by my GP to take medication for a minor ailment. When I said I was pregnant she took out a reference book and looked up the antibiotic in question, quoting for my benefit, “no evidence of harm”. She then snapped the book shut and wrote out the prescription.

The difference between “proven safe” and “no evidence of harm” was either lost on her or not considered important. Of course, it would be impossible for every single doctor to personally investigate every single condition and recommended treatment. They must rely on information given and trust it to be sound. Yet the fact remains that neither she nor I know whether the “no evidence of harm” statement resulted from extensive and long-term testing of this pharmaceutical product or no studies at all on the effects on foetal development.

This I would say is a typical doctor-patient encounter and it reveals some disturbing features of modern healthcare. First of all, it continues to operate on the assumption that safety can be claimed till harm is proven, rather than the assumption that caution should prevail till safety is confirmed.

This is true at least where pharmaceuticals or technical innovations are concerned. (The reverse principle is applied to therapies that are not officially sanctioned, but that is another story.) Secondly, it relies on patients not thinking too much about this distinction, hence the suspension of our critical faculties along with responsibility for our bodies. Finally, to run smoothly it depends on its staff accepting this as a legitimate policy.

In the 1970s Ivan Illich claimed that most of the damage inflicted by the modern doctor occurs “in the ordinary practice of well-trained men and women who have learned to bow to prevailing professional judgement and procedure”.¹⁰ Much more recently, in 2018, a doctor reflecting on his own training pointed out the similarities between medical school and initiation into a cult.¹¹ Members, for instance, undergo years of intense and specialised training, only certain facts and information are permitted while questioning and independent thought are discouraged. Alternative perspectives are entertained at the risk of professional suicide.¹² ‘Initiates’ are bound to the cause not just as a result of massive financial investment (even more substantially in the US than the UK) but no doubt also for deeply personal reasons relating to ethics and identity.

If as a doctor or midwife you were to discover that the information you have been given is unverified, then it may mean years of harming rather

than healing your patients. This is an enormously powerful incentive to avoid that discovery, to adhere rigidly to one's training and to ignore the kind of questions that could lead to a personal as well as professional crisis.

The irony, of course, is that the accusation of cult, or more frequently pseudoscience, is used by establishment figures to discredit those alternative perspectives whenever they gain public prominence. The faith of the general public in medical staff is not a faith in them per se, but in them as the spokespersons of science itself. They are, as it were, the high priests of the new religion. This stems from the belief that medicine – the advice being given to people as patients – is evidence-based. Leaving to one side for now controversies surrounding the quality and validity of much medical evidence, the extent to which practice is informed by scientific evidence at all merits a closer look.¹³

The history of medicine and public health policy are littered with examples of procedures and interventions that have been routinely adopted either in spite of existing contra-indicating research, or in spite of an absence of any research, supportive or otherwise.

In reproductive health care perhaps the most oft-cited example of the former phenomenon is the case of health workers' unwitting role in spreading infectious diseases. While it was empirically demonstrated in the 1840s that hand washing dramatically reduced the incidence of maternal death from puerperal fever, astonishingly it was more than a century before hand hygiene to reduce infection rates was officially promoted in UK and US hospitals.¹⁴

The use of x-ray imaging on pregnant women is a second example. In the 1920s when there were "no known harmful effects on the foetus" radiography was commonly used by obstetricians to screen for foetal abnormalities and other testing. As early as the 1930s studies began to show significant and multiple harms to the foetus and researchers in the 1950s recommended avoiding exposure during pregnancy.

Use of the technology did not, however, rapidly decline until as late as 1975. Even then, it is not clear whether x-ray was abandoned because of the by now strong evidence of harm, or due to the emergence of ultrasound imaging as a viable alternative.¹⁵ Clearly it can take decades or more for practice to catch up with evidence, or for research even to be done to test the safety of a procedure.

5. Routine Ultrasound Screening: Too Much Information?

It is very difficult to quantify what harm stress and anxiety can cause during pregnancy. Certainly there is a body of literature suggesting that calmness, a sense of security and maternal self-confidence all contribute to a positive birth experience and outcome. Then there is the fact that it just makes sense.

Technology often supplies us with information, but it needs to be considered whether more information in itself is always a good thing, especially when it is presented in the somewhat obscure form of statistical probabilities.

During my first pregnancy, at each scan I underwent, a slight concern was raised which resulted in an additional scan as a precaution. At each subsequent scan the initial concern was ruled out as a potential problem, yet a new potential problem was detected. In the end my total of five – or was it six? – hospital scans had no bearing whatsoever on the actual birth, and none of the concerns raised by the scans were ever mentioned to me again by any of my caregivers. Was this harmful for my developing baby? I do not know. It most definitely was not helpful for either of us.

In the UK, routine ultrasound screening is offered at approximately 12 weeks, 20 weeks and sometimes 34 weeks as part of the standard care package. Hand-held Doppler scanners, which measure blood flow rather than produce bone or organ images, are offered or can be requested at antenatal appointments after the first trimester to enable the mother to listen to the baby's heartbeat (i.e. they are often used when there are no clinical indications of a problem).

There is a widespread belief that both types of scan are themselves not harmful and that routine scanning makes the whole process safer. In other words, scanning reduces the inherent risks of pregnancy and childbirth in general. However, a number of systematic reviews of research studies spanning three decades of screening have found to date no evidence that routine (i.e. all women as opposed to only those at higher risk) use of ultrasound imaging either in early or late pregnancy improves infant survival rates or reduces any other adverse outcomes for mother or baby.

The reported benefits of the 12 week scan were the early detection of multiple pregnancies and improved gestational dating.¹⁶ As for Doppler ultrasound, a further review by the Cochrane Foundation in 2015 found not only that there are no studies which identify any benefits of screening all women, but that it may lead to “unnecessary interventions and adverse

effects”¹⁷ In the light of these findings, both the World Health Organisation (WHO) and the National Institute for Health Care and Excellence (NICE) recommended that Doppler ultrasound should not be routinely used in uncomplicated pregnancies.¹⁸

This cautious approach is not reflected in antenatal care. During my first pregnancy I was offered the opportunity to listen to my baby’s heartbeat at every community midwife check-up, meaning my baby had the potential to be exposed to Doppler up to 10 times. This was in addition to the five imaging scans deemed necessary (yet ultimately irrelevant) in the hospital clinic. A Pinard stethoscope (shaped like a hollow horn placed on the womb that you listen into) is in most cases an effective way for midwives to check the baby’s heartbeat in utero, but at no point was this alternative presented to me, nor were any risks ever mentioned. My midwives were either deliberately ignoring the evidence base, which I find unlikely, or they were as ill-informed about it as I was.

So much for the benefit side of the scanning equation. What about the risk of harm? When speaking of potential harm we can look both at the direct effects on the unborn baby and indirectly at any events or chain of events that may occur as a result of an initial scan.

Dealing with the latter first, we know that scanning is supposed to reduce risk. However if – as is often the case – information derived from a scan leads to separate purely precautionary interventions, such as the artificial induction of labour or a caesarean section – which themselves come with their own risks attached – then perhaps these should be factored in as a risk of scanning.

The second possible indirect cause of harm relates to the question of reliability. That scan results are not always accurate is again something which is not routinely made clear to women undergoing the procedure. The rates of misdiagnosis are, according to one study “not insignificant” and a review in the *Obstetrician and Gynaecologist* states that it is misdiagnosis which poses “the greatest danger to the fetus in prenatal diagnostic ultrasound”^{19, 20} False positives or diagnostic misclassifications may lead to unwarranted physical interventions and/or unwarranted psychological distress for parents.

In terms of the direct effects of repeated exposure to ultrasound on human foetuses, to date there is no evidence of harm. Yet, we come back to the point that no evidence of harm is not evidence of safety. The x-ray debacle should have taught us that at the very least. We could have some greater measure of confidence if investigations into its effects were numerous and robust but, they are not. After assurances of an excellent record so far, the second most common theme in documents concerning the safety of diagnostic ultrasound relates to the significant gaps in our knowledge, a lack of data and the need for more research.

A further recurring theme that ought to send alarm bells ringing is the amount of information that is tacitly assumed or “expected” to be the case rather than actually known.

The first major problem when it comes to safety claims is that most epidemiological evidence which still informs recommendations is derived from studies carried out 20-25 years ago. This evidence is called into question because since regulatory changes were made in the early 1990s, manufacturers of scanning equipment have been allowed to increase the acoustic output intensities of their machines by “10-15-fold”.²¹ In Europe there are no legal requirements for acoustic output but it is “expected” that all equipment used in the UK would conform to North American standards.²²

According to the British Institute of Radiology (BIR), “no epidemiological or other evidence was then, or is now, available to support the assertion of safety at these higher exposures”.²³ Despite this, the new levels were approved for all diagnostic purposes, including foetal examinations.

Not only is the modern generation of scanners untested on human beings, but the developing trend in antenatal care is both a greater number of scans and scans at earlier and earlier stages of pregnancy when the embryo “is known to be highly sensitive to damage by physical agents”.²⁴ Laboratory investigations conducted on animals have documented that pulsed ultrasound can, through the elevation of temperature, damage biological tissue. Another study re-iterates that we simply do not know what the “synergistic effects” of “raised body temperature (febrile status) and ultrasound insonation” might be because it has not been researched in depth. Although the available data is insufficient to conclude that exposure leads to adverse effects on the foetus, these effects cannot be ruled out.²⁵

Given that there are so many recognised unknowns in ultrasound technology, and that the relevance of animal models to human beings is poorly understood, it is unsurprising that professional bodies (such as the British Institute for Radiology, Royal College of Radiology, British Medical Ultrasound Society) as well as the medical research community strongly emphasise the need for caution, urging that ultrasound be used only for clinical reasons and that practitioners are well trained and informed about potential hazards and how to reduce them.

Yet, and this brings us to the third major problem with ultrasound safety, there is again a profound disconnect between the science and routine practice. Although all machines are now equipped with indicators displaying acoustic outputs, it is entirely the user’s responsibility to assess safety and control energy levels.

Safety indicators encourage “self-regulation” by users on the basis of “assumed knowledge of the implications of biophysical interactions”.²⁶

Currently, no measures are in place to ensure, or systematically check, whether safety principles are known or being applied.

I am not arguing that ultrasound is not a highly useful, potentially life-saving (and, let's face it, frequently life-ending) medical innovation, or that pregnant women should not have a right to access it. Nor indeed can anyone state definitively that it is harmful, or that a woman is making a bad choice if she decides, once supplied with all the relevant information, to opt for a routine scan.

I am arguing that the phenomenon of ever-increasing and indiscriminate use of the technology is less an example of evidence-based medicine in practice and more an illustration of how vast experiments continue to be carried out on an un-informed and thus un-consenting population. That it is largely a leap into the unknown might be grudgingly admitted by experts in the field and available for anyone to discover amongst the pages of medical publications, yet this fact has not had an impact on antenatal care nor has it filtered into the public consciousness.

The problem of not knowing what the long-term effects might be is exacerbated by the reality that once a practice (or a drug or a vaccine) has become nearly universally adopted, it is very difficult to properly investigate either its effectiveness or safety. In the absence of a control group (i.e. a cohort of women who have not had any scans), one can only compare more with less, never something with nothing. When it is commonly accepted that the benefits outweigh its risks, it can then be argued that it would be “unethical” to create a genuine control group because this would be withdrawing those benefits from that group. Even if, as in the case of foetal ultrasound, the overall benefits have been assumed rather than proven. Thus through a combination of circular logic and dubious ethics we leave the realm of fact and enter the realms of fear and faith.

6. Forging Our Own ‘Pathway’

The 12 week scan has become the key rite of passage culturally for the pregnant woman as she completes the first trimester, and it is truly a wonderful moment hearing your baby’s heartbeat for the first time and sharing his or her image with friends and family. Yet this purely emotional-social aspect ought to be separated from the complete fabrication that routine scanning makes pregnancy and childbirth medically ‘safer’.

My own choices the second time around were motivated not just by the question of potential harm but the desire to be left in peace to experience my pregnancy directly, not one stage removed through the medium of technology. I knew exactly how repeated scanning can create a perpetual state of unease as one is bounced from one expert to another, from one hypothetical complication to another. None of this, however, not my knowledge, my history or my values, made the slightest impression when up against ingrained paternalism and an unwavering commitment to standard practice. At what point did it become impossible to bring our own personality, our own self, into the room when we engage with health professionals?

Ultimately, we cannot even begin to establish relationships of mutual respect and mutual trust until we respect and trust ourselves enough to demand them. The cultural norm of instantly informing a medical professional at the first signs of conception is symbolic of the extent to which women have relinquished their agency under the guise of responsible and above all safe behaviour. Acting responsibly has come to mean doing what is expected of us, despite this being the opposite of true responsibility. Would I advocate ignoring all medical advice? Of course not. But perhaps we can take steps to claw back some of the ground that has been conceded to the health industry over the past decades. Perhaps we could take stock of what genuinely lies within the remit of the medical expert, and where we might be able to rely on ourselves, our families and communities for care and support.

Our total dependence on these “services” is not a given; otherwise there would be no need for the continuous mobilisation of resources which erode our confidence in our own understanding, capabilities, bodies and instincts. As mothers we have the most awesome power, and that is to shape the worldview of the next generation. As role models, are we going to set them on a path toward compliance, or freedom?

Notes

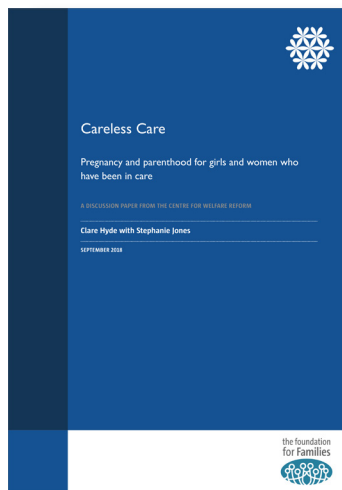
1. Patricia Spallone, *Beyond Conception: the new politics of reproduction*, Macmillan, (1989) pp. 38-9.
2. None of this is written in ignorance of the enormous benefits of modern medicine, particularly in the fields of emergency care and surgery. Moreover, I by no means believe that practitioners are bad people or deliberately trying to mislead us. On the whole they are incredibly well-intentioned, skilled and caring.
3. I do not like to use the term 'patient', for pregnancy is not an illness, but for want of an appropriate word.
4. The threat of litigation may be a factor here. But a blame culture is merely the other side of the same coin.
5. Jo Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*, Cork University Press, (1998) p.8.
6. For instance, reasons for artificially inducing labour include being over a certain age, over a certain weight, having too high blood sugar levels, baby being too small, baby being too large, amniotic fluids being too low, amniotic fluids being too high...the list could go on. Of course, the risk factors increase in line with the development of the technologies used to measure them.
7. As it turned out, my body – or perhaps my son – had different ideas and I would have had to go into the hospital anyway. But that does not change the fact that it should have been my decision where to at least plan to have my baby.
8. For instance, relative risk could be presented as a 100% increase but the absolute risk may only increase from 1 in 1000 to 2 in 1000.
9. Alberto Donzelli, '*Influenza Vaccines for All Pregnant Women? Better Evidence is Needed*', INTERNATIONAL JOURNAL OF ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH, 2018, 15 (9).
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ABOUT THE AUTHOR

Maria Lyons is an independent researcher with a PhD in Politics and Government. She has written about inclusion, intellectual disabilities, the meaning of work and education. More recently she has been focusing on the ways in which economic and social policies are affecting children and families. When she can fit it around being a full-time mum, Maria delivers courses in academic skills and also teaches English as a second language.

Email: maria.s.lyons@gmail.com



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