Thinking outside the box

Who safeguards mothers?

Sara Wickham asks who is with women who want to decline prophylactic treatment for their healthy baby

I’ve been researching and writing about group B streptococcus (GBS) and early-onset GBS disease all summer (Wickham 2014), and this has entailed having lots of conversations - both verbal and written - with women who have made different decisions in this area. I’ve talked with women who had a risk factor and wanted antibiotics, women who were concerned about the side effects of antibiotics and wanted to wait and see, and women who sought private screening for GBS because they wanted to know their carriage status despite routine screening not being recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) (2012). This only scratches the surface, of course, and there are many other viewpoints as well. The women I want to consider in this article are those who did not choose to be screened for GBS, but who were coincidentally found to have GBS after having a swab or urine test for another reason. Some of these women decide they do not wish to have antibiotics for themselves or their baby, and I have become concerned, because these are the women who seem to be least able to get their needs met at the moment.

GBS decisions in labour

While routine screening for group B streptococcus is not recommended in the UK, women are sometimes coincidentally found to be carrying these bacteria during investigations of symptoms in pregnancy. If such women decide to decline intravenous antibiotics for themselves in labour, they can seek support from midwives in appropriate roles. But once the woman’s baby is born, the situation changes somewhat, as the legal context changes and the issue of safeguarding may be raised. This article considers the issues that arise in such scenarios and raises questions about who is there to support women who experience pressure to consent to their healthy newborn baby having prophylactic intravenous antibiotics.

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GBS decisions in labour

Although routine screening is not endorsed in the UK, the RCOG (2012) recommends that intravenous antibiotics should be offered to any woman known to carry GBS once she goes into labour. National guidance reflects the finding that, while antibiotic prophylaxis has “reduced the incidence of EOGBS disease, it has not been shown to reduce all causes of mortality or GBS-related mortality” (RCOG 2012: 2). The RCOG also expresses concerns about the disadvantages of routine screening and antibiotics, which “include anaphylaxis, increased medicalisation of labour and the neonatal period, and possible infection with antibiotic-resistant organisms, particularly when broad-spectrum antibiotics such as amoxicillin are used for prophylaxis” (2012: 2). Ultimately, though, we live in a culture which prioritises action over thought and in which many professionals fear that they may get into legal or professional trouble if they do not do as much as possible.

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Antibiotics and babies

But what happens in situations where a woman successfully navigates herself through declining antibiotics in labour, only to encounter a paediatrician or neonatologist who feels that antibiotics should be given to her healthy, asymptomatic baby? This is not uncommon amongst women who decline antibiotics in this situation, and it often leads to incredibly distressing conversations at a time when women are feeling tired, sore, vulnerable and more in need of kindness, understanding and support than ever.

It’s not that this is an outrageous choice to make, either. The risk of GBS disease in a healthy, term baby is low, and although the overall mortality rate in babies who experience GBS disease sounds scary, I have heard too many people quoting this without then being clear that the mortality rate for healthy, term babies who develop GBS disease is around ten times lower than the mortality rate for preterm babies (Centers for Disease Control and Prevention (CDC) 2010). I don’t want to underplay the potential consequences of GBS disease or the experience of affected families, but antibiotics are also not without consequences and bacteria are a normal and important part of being born and being human. All of the current treatments for GBS, whether antibiotics or alternatives, are not only under-researched; they are specifically designed to remove all bacteria, good or bad, and not just GBS. It is not unreasonable to be concerned about giving prophylactic antibiotics to a healthy newborn baby.

But too many women, and some of them the same women who were really well supported by a SoM when they decided to decline antibiotics for themselves in labour, are spending their first hours as a new mother battling with staff in an attempt to have their wishes for their baby respected. What can I tell them? I can explain to them that, while no-one can force a woman to make a particular decision while she is pregnant, once her baby is born it has rights of its own and neonatologists have a duty of care to the baby. I can explain how this changes things; that doctors can access a degree of legal power if they feel that treatment is in the child’s best interests. But who is there to advocate for the mother?

Who is ‘with mother’?

I posed this question to a handful of friends who are SoMs, and had some interesting conversations about how the role of a SoM isn’t always clear-cut. Many women and families in the situation I have described are more likely to meet a safeguarding midwife (or nurse) than a SoM, but while some of those in a safeguarding role have been very supportive to women in this situation, this is by no means guaranteed. As with the neonatologist, the primary concern of the midwife in this role is to advocate for the baby.

To whom can these women turn for help, advocacy and support in making a decision that, in almost every case that I have encountered, is based on concern about protecting the long-term health of their baby? They may be being cared for by lovely (if overstretched) postnatal ward midwives, but these midwives are hardly able to leave the ward in order to stand by the side of a woman wanting to go against the advice of a neonatologist. I am not challenging the value of safeguarding, or the need for advocacy for babies, but surely there ought to be somebody on staff whose role it is to stand by and advocate for women not just until they give birth but throughout the childbearing year.

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References

