

WHAT DO WOMEN WANT?

A paper by Beverley Lawrence Beech - Hon Chair, Association for Improvements in the Maternity Services presented to the Royal Society of Medicine on the 16th March 2007

I feel that it may be helpful to understand on what basis I am here this evening to speak about what women want. What is AIMS? AIMS is a campaigning pressure group, founded in 1960, by a woman called Sally Willington, our current President, who spent six unforgettable weeks in an antenatal ward and wrote to the national newspapers about the way women were treated. I joined AIMS in 1976 and I have been involved with helping women get the kind of care they want, or help them complain about the care they had, if that is what they wish to do.

AIMS has a national Help Line and we also provide a web site and email address which respond to appeals for help. There are twelve women on the AIMS committee and every one of us is in daily contact with women and we also have the added advantage that some of us have been around for a long time and have that historical knowledge that can be so useful. Our contacts are not only parents but also professionals, midwives, health visitors and the occasional obstetrician or paediatrician.

What do women want?

The very question, ‘what do women want?’ trivialises the enormity of birth and its impact. The language of want is the language of consumerism, whereas the language of birth is about relationships, health and well-being, support, nurturing. Wants do not occur in isolation - they are formed in the context of women's lives and what is around them - therefore the onus is on services to provide the very best to each woman, and raise women's expectations of their lives rather than decrease them.

Nadine Edwards in her book *Birthing Autonomy*, compared how differently the pros and cons of home births are constructed and contemplated by mothers and by the medical and midwifery professions, and looks at how current obstetric thinking and practices can dis-empower and harm women emotionally and spiritually as well as physically.

Trivialising birth experiences

The impact and importance of women's birth experiences is trivialised throughout our society. In February, the BBC's *Woman's Hour* presenter, Penny Marshall, in a programme entitled the ‘Battle for Birth’ made reference to “a lot of grumbling by the

chattering classes and the middle classes about their birth experiences, [and] very high expectations” and asked her interviewee, “how much of your time is spent worrying about disappointed middle class women who have had disappointing births?”

She asked that question despite earlier in the programme being told by Baroness Julia Cumberlege the author of the “Changing Childbirth Report” (1993), that, “when we went out and about and talked to hundreds of women it was the women who were least articulate who wanted exactly the same things as those who were very articulate”. And that is exactly what AIMS finds. There is no difference in what women want by social class, but there is a considerable difference in their understanding of the issues and their rights. It was for this reason that I wrote ‘Am I Allowed?’ in 2003, because Am I Allowed? is one of the most common questions women ask.

The majority of women do not understand that it is their body and their baby and the medical and midwifery professions are there to advise them. In the 1970s women believed that once they stepped inside a hospital they had to do what the staff wanted, and that view persists and is encouraged by the language that is commonly used:

We do not allow first time mothers to birth at home

You have to see the obstetrician to discuss whether or not you will be allowed to birth in water

You cannot have a home birth because your blood count is below 10.

You have to have a hospital birth because you have antibodies for Strep B.

This is not the language of partnership

The propaganda about childbirth claims that the majority of women are ‘satisfied’ with their birth experiences. This is not AIMS experience, and we find that the vast majority of the questionnaires asking for women’s views are superficial (Teijlingen, 2003). Stop any woman in the street and ask her if she was ‘satisfied’ with her care she will, often after a small pause, say yes. Spend half an hour talking to her about her experience of birth and you will find that she is not satisfied at all.

Birth Plans

She may have filled in a birth plan, either one she has devised herself, or one that is supplied by the hospital, but so often women who fill in birth plans do not have their expectations met. Indeed, research from Heatherwood Hospital (Jones, 1998) found that women who completed birth plans have more interventions than those who do not, and the researchers speculated that the higher prevalence of forceps delivery may reflect an unintentional lack of support from irritated attendants. The research suggests that it’s dangerous to want anything because you’re less likely to get it – where else in society does that apply?

Birth plans developed as women tried to establish some control over their birth experiences and it was not long before hospitals began producing their own birth plans which offered women a selection of options that the hospital had decided were suitable to be chosen. In Huddersfield, some of the choices the women were able to choose were wearing their own nightdress; 'correcting a slow labour by rupture of membranes; 'correcting a slow labour by an intravenous infusion; choosing to have a partial shave, an enema or an episiotomy (Jackson, 1986). Interestingly, one third of the first 100 women to use this birth plan chose to have pubic shaving. Women at that time would choose to have public shaving because they believed it was beneficial to do so and were unaware of the research showing that pubic shaving had no benefit and, indeed, could cause infections.

Indeed, research by Porter and MacIntyre (1984) showed how women believe that what is provided must be best, so when offered a choice with no information to evaluate it they choose what is on offer; and what is on offer for the majority is high technology deliveries. Women are still having high rates of induction and acceleration of labour and the caesarean section rates have increased from 9.6% in 1977 to over 23% now.

Too Posh to Push

Our newspapers, magazines, radio and television delight in headlines like 'Too Posh to Push' and the focus of their attention is invariably on the minority of women who choose to have a caesarean operation. The implication is that the problems with the unacceptably high caesarean section rates are due to women choosing to subject themselves to major surgery. In our experience, fewer than 1% of our enquiries about caesarean operations are from women who are determined to book a caesarean. Of those women who say they want a caesarean we find they break down into some distinct groups:

Those who have had previous dreadful birth experiences or whose friends or relatives have had similar experiences and they are terrified that this will happen to them.

Those who have had a previous caesarean section and are told that they have to have another one

Those who are expecting babies by the breech, or have twins, and have been told that they have to have a caesarean.

Those who do not want their cervix or sex life ruined.

In all the years that I have been advising women I recall only three women who were absolutely determined to have a caesarean for that reason. These far outnumbered by the women who are told they have to have a caesarean and are desperate to avoid one.

A caesarean operation may be perceived as a simple affair for the doctors, for the woman the effects last very much longer. Recently, a woman who had been determined to have a vaginal birth after a previous caesarean sent us this comment:

The obstetrician, while stitching her up after a ventouse assisted delivery said,

"Well, don't you wish you'd had a planned caesarean now?"

To which the woman replied

"No. Tomorrow I shall be able to pick up my toddler." (AIMS, 2007)

Informed consent

Answering the question, what do women want is complex - because it's difficult to choose things of which you have no knowledge and it's often when women have had brilliant care, that they understand the benefits of it and want it again.

Jo Green and colleagues in their prospective study of women's experiences of childbirth found that whatever women wanted before birth, those who were most satisfied were those who had least intervention (Green, 1998).

Informed consent is one of the current buzz words and no-one can make an informed decision about their care and what they want if they do not have enough information to weigh up the pros and cons and decide what is best for them.

Edwards in her book gives the example of the woman being told about all the advantages of her baby having vitamin k and asking, 'if there are only advantages, why am I being asked to make a decision – and also being aware that the information she was receiving was from a practitioner who wanted her to agree to it, and was only providing her with one side of the debate'.

Lack of information, not only about each intervention, but the collective impacts of interventions – what Sally Inch describes as the 'cascade' of intervention is not readily given to women, and it is one of the reasons AIMS has developed a range of books and leaflets in order to inform them

Pain of Labour

We live in a society which is bombarded by adverts suggesting that the slightest headache can be overcome by taking a pill and while there are many women who would not dream of taking over-the-counter drugs during their pregnancy they are more than willing to book their epidurals or accept drugs during labour. They become overwhelmed by the irresistibility of technological birth once they enter a hospital environment (Machin and Scammel, 1997) and many are unaware of the adverse effects the drugs can have on their labours and the baby.

But why is it that those women who want to book a water birth, or use water for pain relief in labour have an uphill battle to get it? Few hospitals have any more than a single pool, and even when they have more than one few women are encouraged to use them. A survey that AIMS did in 2000 revealed that many of the women booking into their local hospitals had no idea the unit had a pool, let alone being offered its use (Beech, 2000).

Normal birth

The majority of women anticipate having a normal birth, and, indeed, most childbirth classes prepare them for that eventuality. What they do not do is warn them that the place of birth has a very significant impact on their chances of achieving a normal birth and when the woman ends up with an obstetrically managed delivery she invariably believes that it was her fault – she had an incompetent cervix, she failed to progress.

Perceptions of normal birth are confused by the failure to understand the effects of most of the routine interventions in labour. A woman can book into hospital, have her waters broken, a drip set up, an epidural and an episiotomy but, if she pushes the baby out without forceps or ventouse she will have ‘normal delivery’ written on her case notes. Hospitals publish statistics where normal birth is claimed for any vaginal delivery without forceps or ventouse. This failure to acknowledge that the moment a woman has her waters broken, a drip set up and an epidural in place (or any one of those procedures) her labour is no longer normal, the physiology has been altered. So women who have been through that experience who say ‘never again am I going to have a normal birth like that one I want to book a caesarean section’, are taken aback when it is pointed out to them that they did not have a normal birth they had an obstetric delivery and there are things they can do to give themselves the best chance of a normal birth they next time.

In 2001 Soo Downe published the results of her prospective survey of labour interventions associated with normal birth. Her analysis of births that did not include, induction, accelerations, ARM, Epidurals and episiotomy revealed that only 1 in 6 primips had ‘normal’ births and only 1 in 3 multips had ‘normal’ births. Yet hospitals claim normal birth rates around 40%.

The fear factor

The perception of risk is particularly thrown into the spotlight by women who want a home birth. It is common for the woman to be told that a senior member of staff has to visit her to explain the risks, or that she ‘has to see the consultant’ so that s/he can explain the risks. Frequently, women are told about the perceived risks of home births, often in graphic details, but I have yet to hear from a woman who was first of all told the risks of home birth and then told the risks of a hospital birth so that she can properly weigh up the risks in her particular circumstances.

My experience of antenatal care was that they make you anxious and then try to reassure you. (Edwards, 2005).

Women’s perception of risk is often very different from the professionals’ perception. They will warn of the risk of unexplained stillbirth if the woman goes over 40 weeks. For example, the woman will remember that her mother went to 43 weeks before she was born and she will consider the risks of travelling 15 miles to a maternity unit when she is likely to give birth very quickly – she considers the risks of giving birth in an

ambulance at the side of the road instead of in the comfort of her own home, and weighs up the issues, often coming to a decision contrary to the wishes of the staff.

The medical model of birth relies on seeking out and focusing on risk and this focus undermines women's confidence in their ability to birth. It makes them unnecessarily fearful. Combine that with admitting her to an unfamiliar place, leave her alone with her partner for long periods and put pressure on her to perform within a limited time period, and attended by midwives and doctors who are run off their feet and seriously short staffed and you have a recipe for problems. How many of the caesareans performed today are to save the woman from the problems the present system caused?

Fear pervades the whole of maternity care, fear that something will go wrong, fear that the woman will sue, fear that colleagues will criticise if protocols are not adhered to.

Yet, despite the propaganda, women are reluctant to complain and so often they make excuses for the staff when they had sub-standard care. They acknowledge that the midwives were rushed off their feet, that there was only one midwife on the whole postnatal ward. They are also worried that if they complain they will be treated poorly the next time they come into hospital, and I regret to say many of them are absolutely right.

By privileging the obstetric model of care over social birth practices, midwives knowledge and skills and how they relate to women are muted so that midwifery becomes restricted to detection of abnormality through set practices of surveillance – midwifery by numbers. While the midwifery skills that provide a therapeutic and caring relationship and professional friendships which nurture trust and engaging with the woman's individual circumstances are restricted.

Tick boxes and Protocols

We have developed, with the best of intentions, a system of maternity care by tick boxes. Protocols were developed and randomised controlled trials introduced to establish the optimal care available and provide a structure which would advise practitioners of best practice. What protocols and tick boxes, or randomised controlled trials cannot do is tell you what is the best approach in this particular circumstance, at this particular time, with this particular woman, on every occasion. That is where clinical judgement comes in. But so many staff are now so fearful of making a clinical judgement that deviates from the protocol that they are prepared to bully or inveigle the woman into co-operating with what they want.

So what can be done to respond to women's needs and the needs of the staff? We know that small, free standing, midwifery units, community based midwifery teams and case load midwifery all enhance the midwives' practise, encourage her to develop her skills, reduce the caesarean section rates and enable a fit and healthy woman to have a good start at mothering, as Walsh has described in his ethnography of free-standing birth centres (Walsh, 2006), and it is a disgrace that the one group of midwives, the Independent Midwives, who provide the Gold Standard of midwifery care are now under threat because of the failure of the Royal College of Midwives and the government to enable them to have insurance cover. Free-standing birth centres and community based midwifery respond to women's need to be attended by someone

they know and trust and with whom they have developed a relationship. One cannot develop a relationship with a large team. They also have the advantage that by removing fit and healthy women from the obstetric units the obstetricians will be enabled to concentrate on those high risk women who need their care. There will be less pressure to rush women through the units and there will be time to give those women the individualised care they need. The woman who has a difficult pregnancy and who is worried about her baby's survival has even more need for individualised care from the obstetric team.

The Government propaganda strives to put women at the centre of care. If that is to happen then we have to recognise that the majority of women want care from a person with whom they have developed a relationship and who will respond to their needs.

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