AIMS For a better birth...

Challenging the illusion of choice

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While many Trusts pay lip service to the idea of choice, in reality, most women have no choice at all in the kind of maternity care they receive. Beverley Lawrence Beech reviews Choice in Maternity Services, the Ninth Report of Session 2002-03, Volume 1, House of Commons Health Committee - document that may help change things

In June this year, AIMS submitted its evidence to the House of Commons Select Committee on Health on choice in the maternity services and was invited, to give evidence at a public session in the House of Commons. The Independent Midwives Association, Royal College of Midwives, Association of Radical Midwives, National Childbirth Trust and Royal College of Obstet-ricians and Gynaecologists were also invited to give evidence.

This session was followed by similar meetings during which the Committee questioned Baroness Cumberlege (the Chair of the Expert Maternity Group that had been established by the Government to take forward the recommendations of the previous Select Committee) and representatives of the Department of Health.

In July, they published their report. Although this report does not go as far as AIMS would like, it does, nevertheless, include some radical suggestions, and it will be interesting to see what the Government does about it.

In the introduction to the Report, the Committee drew attention to research showing how women did not feel in control of their births; they had high levels of interventions and there was a paucity of research into the effectiveness of the service provided.

It commented: "For most women, giving birth is a normal physiological process, not an illness. It is not clear to us that the usual methods the Department employs to measure the effectiveness of services (which must inevitably focus on clinical outcomes) are necessarily the most appropriate for maternity services."

An illusion of choice

The Committee also accepted that there was an 'illusion of choice'. "We note the Leeds University research which suggested that high levels of intervention in care had militated against better psychological outcomes being achieved as a consequence of greater choice. The Department needs to ensure that women are given a genuine and informed choice, and not the illusion of choice that some of

our witnesses suggested was currently the case."

Who should provide care?

When considering who should provide care, the Committee recognised that some women found it hard to access maternity care without a referral from a GP, and even NHS Direct failed to suggest any other option.

It suggested that "women should be encouraged to contact midwives as their first port of call and to at least be aware of their right to have a home birth without seeking the GP's permission", and they recommended that each pregnant woman have at least one initial "booking appointment with a community midwife who has in-depth knowledge of local services ..."

It also stated that "We feel that the current delivery of maternity services, which is generally led by acute general hospitals, over-medicalises birth. Through the NSF (National Services Framework), PCTs (Primary Care Trusts) should be given a lead role in ensuring there is choice and community- led services for women, wherever they live."

Choice in where care is provided

The Committee highlighted the fragmentation of services across the country and the closure of small maternity units despite research showing lower rates of analgesia, lower rates of caesarean section and better birth experiences for women.

It asked the Department of Health what steps it could take to ensure the viability of community services and was told that "the configuration of services was a matter for local trusts and Strategic Health Authorities to determine". One wonders what use this will be because the local services are heavily influenced by obstetricians and male administrators, so little will change there.

The Report rather weakly commented that "We accept that local configuration of services is a matter for local determination, but given that pregnant women are not able to travel long journeys to give birth, if midwife led units are not available, local choice is severely constrained."

But then went on to say: "We believe that our recommendations above, calling for a shift towards midwife bookings, greater autonomy for midwives in delivering services and sufficient priority given by trusts to maternity issues would reverse the worrying medicalisation of birth reported to us."

Home birth

Having quoted the research showing that home birth is as safe as hospital birth, and results in less intervention and less morbidity for mothers and babies, the Committee went on to say: "We support the Secretary of State's policy goal of making home birth more widely available, but are disappointed that nothing has been done directly by the Department to achieve this over the two years since his statement." The report quotes AIMS' evidence of the tactics used towards the end of pregnancy to

'persuade' women to go into hospital and commented that: "We regard this treatment of women particularly at such an important stage of their pregnancy as wholly unacceptable."

The Committee then recommended: "If trusts have staff shortages, they should call on the services of agency staff and independent midwives so that women in hospital and at home do not have to face the prospect of not being properly supported in labour." And further stated: "Rather than perceiving home births as a potential drain on scarce resources, we see them as a gateway to promoting normal birth and a spur towards midwife recruitment and retention. We endorse AIMS' recommendation that all trainee midwives should be obliged to attend a minimum of three home births as an essential part of their training."

Choice in how care is provided

During the evidence session, it was told by AIMS, NCT and midwives of the difficulties in booking into a hospital of one's choice or even changing hospitals. The Committee took this on board and recommended: "If a woman wants or needs to be cared for in an acute hospital setting, she should also be offered a choice of different acute units where this is practical."

And went on to say: "The inquiry recommended that individual consultant data on, for example, the caesarean rates of different consultants, together with national and local comparisons, should be given to all users." Professor Dunlop, the RCOG spokesman, commented that he "thought there would be 'no problem at all' with such a recommendation provided that the data took account of the different case mix of units, and we accept that this is an important requirement".

Choice in how care is provided

The Committee reflected on the 10 indicators for success identified by Changing Childbirth (Expert Maternity Group, 1993) and acknowledged, rather depressingly, that "significant success" had only been achieved in three: Women holding their own notes; the number of women delivered in maternity units being admitted under the management of a midwife; and "reviewing the number of antenatal visits for women with uncomplicated pregnancies". Some success had been achieved in two other indicators: "midwives having access to some beds in maternity units but certainly not in all the ways envisaged by the [Changing Childbirth] report; and on information available to all women about local services."

When considering scans, tests and procedures, the Committee noted the NCT's comments that "although the Department suggested 'a woman can choose whether she wants the tests'... too little is made of their optional nature". The Committee concluded: "We do not believe that simply making tests available is in itself an extension of choice. Testing and screening sometimes inhibit rational choice and sometimes encourage higher levels of interventions."

The Committee noted that the evidence- based guidelines on induction of labour were being interpreted in very different ways across the country. It recommended that: "women should receive evidence-based information on the balance of risks and benefits of induction of labour at different times, so that those

whose pregnancy continues beyond term can make informed decisions about whether to accept the offer of a medical induction at around 41 weeks or at any stage thereafter. Where women refuse treatment, their decision should be respected."

Birth suites

The Committee acknowledged the evidence from several witnesses of the inappropriateness of the typical hospital delivery suite that limited women's choices, medicalised birth and prevented freedom of movement. It suggested that: "If the arguments of the NCT and AIMS are soundly based, and hundreds of thousands of women are being asked to give birth in wholly inappropriately designed rooms, this would be a matter of very great concern. We are not the appropriate body to judge on such clinical matters, but we suggest that the National Institute for Clinical Excellence [NICE] should be able to investigate this important issue as a matter of priority."

Members of the Committee were not impressed either on hearing how some trusts allowed several birth partners to be present during birth while others permitted only one.

"We do not think that it is reasonable that women should be limited to a single birth partner in any circumstances. Such an attitude suggests birth is being managed for the convenience of the unit rather than the mother. We look to the Department to support the view that women should not be limited to a single birth partner."

Birth pools

In highlighting the issue of providing birth pools and staff willing to support women who want to birth in water, the Committee drew heavily from AIMS' evidence of the kind of problems women face and the tactics used to dissuade women from using them. It quoted a comment from Sarah Montagu, a member of the Association of Radical Midwives: "It struck me as quite bizarre that it seems optional for management that, if midwives from a unit feel that they do not want to support women in water, they do not feel they can force the midwives to train to look after women in water. If a midwife said, 'I do not feel I want to look after women having epidurals or caesarean section', the managers would tell them not to be stupid and that it was part of the job."

The Committee recommended that: "We think it is unacceptable that midwives should be uncomfortable in dealing with mothers using birth pools: this is a matter that should be addressed in training and through professional development. We agree that it should not be acceptable for midwives to be unable or unwilling fully to support women using birth pools."

Caesarean sections

Although there is a lengthy section on caesarean sections and how this restricts women's choices, especially when obstetricians are now routinely advising caesareans for women expecting babies by the breech, the Committee made no recommendations.

This had been extensively covered by an earlier report. Members did, however, express the hope of seeing service managers setting themselves objectives to increase normal births as part of an audit cycle.

In addition, in the following section on choice in neonatal and postnatal care in the Report, they expressed a desire that: ". . . the NSF will include choice for women on the length of time they can stay in hospital or in a midwife- led unit after birth and allow for flexible support in the community for up to eight weeks from midwives and health visitors working as a team."

Choice and Litigation

The Committee drew attention to the argument that increasing rates of litigation for birth-related adverse outcomes may be having an impact on clinical decision-making. It drew attention to the Chief Medical Officer's report Making Amends, which proposes reforms to the complaints system and requires a Duty of Candour, obliging all health professionals and managers to be honest in dealing with complaints. It expressed concern that: "the defensive approach to medicine may particularly undermine giving women choice in maternity services, and we urge the Government to implement and monitor any changes with this in mind."

In conclusion, the Report drew attention to two earlier reports: Provision of Maternity Services and Inequalities in Access to Maternity Services, and noted that: "Much of the Government's publicly stated policy in recent months has been to support the 'choice agenda', and we would like the Department to take the steps to give women power to make informed and real choices." The barriers to change often seemed to be, first, the pressure of day-to-day work, which meant they never had the time to think about change and, second, a shortage of resources for training or to release staff for training. It urged the Government to: "consider allocating some one-off resources to maternity units wanting to make changes to their practise so that they could carry out this work. Unlike the £100m allocation the Government announced in 2001 for maternity services, this one-off allocation might be used more to support staff than building improvements."

Altogether, this Report made 26 separate recommendations.

In 1992, the House of Commons Health Committee (Winterton) Report clearly identified the problems in maternity care and just how inappropriate it was for the majority of fit and healthy women to be delivered in highly medicalised settings. Instead of focusing on the true problems, the Government of the day set up Changing Childbirth (Expert Maternity Group, 1993) to focus on 'choice' and now, 10 years later, little has changed-other than even more interventions and the culmination of a successful propaganda exercise to persuade women that, no matter what happened during their birth, the majority had 'choice'.

Over 11 years after the Winterton Report, this new Report reinforces what the Winterton identified and recommended. It will be interesting to see whether or not the Government has the nerve to deal with medical self-interest or whether it will find other ways of avoiding the improvements in care that will provide real benefits for women and babies.

Editor's note: Shortly after this Report was published, Julia Drown, MP, Chair of the House of Commons Select Committee on Health, gave birth-at home-to a baby girl.

References

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