AIMS For a better birth...

A question of choice

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Avril Nicoll picks her favourite article from the 80s

During the 1980s - the decade that saw me through secondary school, college and my first post as a speech therapist - I had no reason to be aware of AIMS or the politics of birth. But look what I missed! Given the fascinating opportunity to peruse the AIMS Journals of the 1980s, I find the now familiar, gripping mix of the campaigning and the personal, with an added sense of tension over the direction AIMS should take.

The articles show frustration with obstetricians and paternalism, and concern over the large-scale closure of GP units. There is much on nutrition, on Marjorie Tew's statistical analyses, the Wendy Savage case and Michel Odent's approach to childbirth. Women are encouraged to express their choices in writing before labour (although I'm not sure it would be advisable today to put that you are 'practised in the psychoprophylactic technique of preparation for childbirth'.) Reflective stories tell of home birth, hospital birth, miscarriage, stillbirth, cot death and even abortion. Every one adds to the reader's understanding of what it means to be a woman and a mother. They also remind us that:

'The birth of every child is a gift to the world, a new and unique beginning. AIMS seeks to ensure circumstances for every birth that allow it to be a time of celebration.' (Autumn 1981, p.1)

So, which article to choose?

In the 1980s I was - unusually for a Scot - an active supporter of Thatcherism. This was because I believed that every individual should have the freedom to do whatever they choose, as long as it does not impinge on that same right of other individuals. I thought if everyone behaved this way - following their own path but always considering others - the world would be a happier and fairer place. On the question of how to achieve this, choice seemed to be the answer.

However, over the years I have become increasingly aware of how much culture, upbringing, economic and social circumstances, the times we live in, our relationship and connections with other people, language and luck all shape our choices. For some time I have been questioning to what extent we can expect greater choice - even when it is 'informed' - to make things better for all birthing women. Perhaps if I had read Nancy Stewart's thought-provoking editorial 'Choice' is not the answer in the summer of 1982, I would have arrived at this realisation earlier.

Nancy says choice 'is not really a valid priority in improving women's experiences of birth' and that, as a

campaigning organisation, AIMS owes it to every woman to 'help her find the way out of the cultural limits, and to embrace her full potential as a woman giving birth.' She argues that, to achieve this, AIMS needs to focus on 'defining the ideal services, and campaigning for their development' rather than promoting the idea of choice.

My experience with the Keep MUM (a maternity unit in Montrose) campaign would bear this out. Women had the choice to go to a midwife-led unit but were increasingly 'choosing' to go to a consultant unit 35 miles away. While our campaign used the defence of choice, the real success came when midwives began to believe in normality and to under stand that it was within their power to make a difference. Now, more than half of all births in the area are in this freestanding unit, over 70 per cent of them in water, and a physiological third stage has become the norm. How much is this down to choice and how much to defining and then offering an ideal service?

While it has become trendy to talk about 'choice architecture' and providing a 'nudge'[1] AIMS has long recognised the need to encourage high aspirations and change through sharing information about good experiences and successful models of maternity care. As Nancy Stewart says,*the range of options is always limited', but 'our effectiveness as campaigners is enhanced if we have a platform to work from, an ideal to promote.*'

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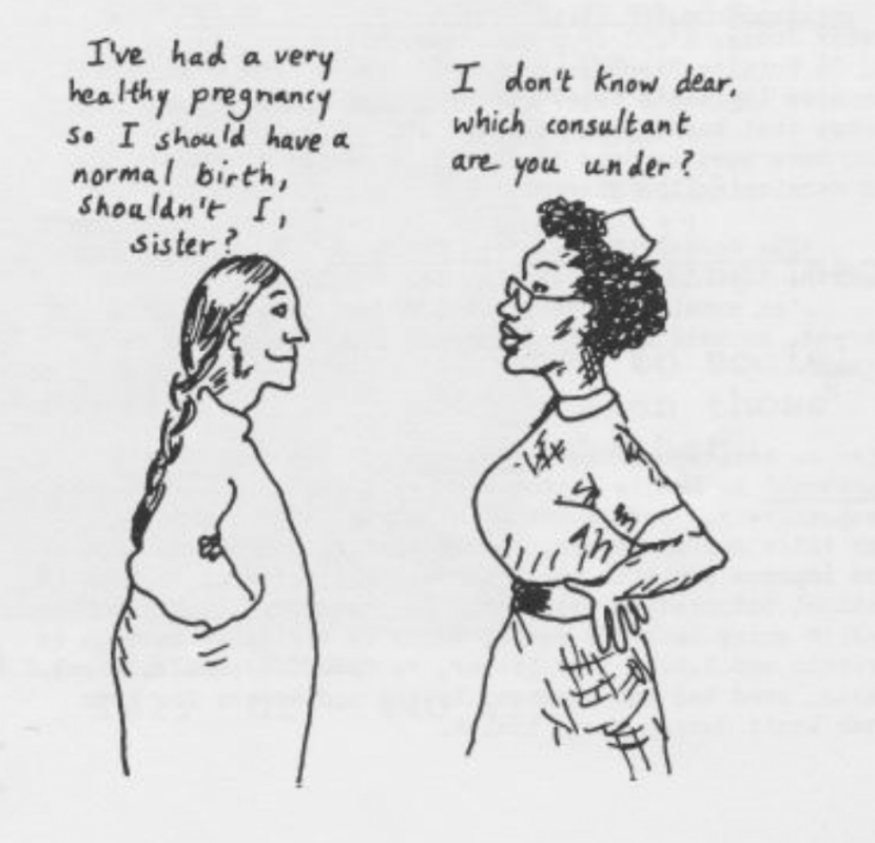


AIMS Journal Summer 1982

Editorial

'CHOICE' IS NOT THE ANSWER

'Choice in Childbirth' has become the byword of those who seek to improve maternity services. But if we look closely at what that means, we may discover that choice has very little to do with our real aims--with providing for good births.

The difficulty in defining our goals which surfaced at this year's AGM has been simmering for some time in AIMS (we haven't yet successfully replaced the 'AIMS of AIMS' leaflet that was obsolete 2 years ago!), as we try to match what we say we are with an evolving sense of what we do. At this start of a new year in AIMS, it is an opportune time to open up the AGM discussion throughout the membership, to begin a debate about our goals in the hopes of reaching a consensus.

Historically, AIMS has stood for 'freedom of choice in childbirth'--and at various times that has meant such campaigns as freedom to bottle feed, epidurals on demand, more readily available pain relief of all kinds. To many people within AIMS, 'freedom of choice' still adequately describes our priority. But for others--myself included--the idea of 'choice' offers limited scope for making real improvements in maternity services; the focus instead is on defining the ideal services, and campaigning for their development.

There has actually been a steady progression of thought within AIMS, both as an organisation and as individuals. We have come more and more to question the routine mechanisation of birth, and the disregard for a woman's innate ability to give birth. We have increasingly seen and spoken out about the potentially damaging effects, both physically and emotionally, of many obstetric practices. And we have increasingly applauded the benefits of supportive midwifery--assisting a woman who is giving birth--over active obstetrics, the removal of a baby from a female body. We have learned through our pooled experiences, and have developed positions based on what we have learned.

We could now take what we have learned and work it into a blueprint for change--our ideal services fostering safe and satisfying birth.

But many in AIMS feel that to define an ideal would be wrong, and that we must be free to respond to changes. If the official wind blows toward a less-interventive approach to birth (the argument goes) perhaps we will need to campaign for more drugs in labour, for newborn nurseries removed from mothers, for inductions on demand. If women want those things which become not readily available (perhaps because of our earlier campaigns?), then we should respond to their needs and support those demands. And how can we presume to define an ideal--times change, and people are different.

Yes. But birth does not change. And it can occur for better or for worse. We have learned that there are intrinsic disadvantages in modern obstetric routines, which carry physical risks to mothers and especially babies, and which can alienate a woman emotionally at this pivotal time in her life. If we are to work for improvements in maternity care, surely we cannot justify any future about-face to support changes which we know are to the detriment of mothers and babies. Widespread anaesthesia will never be better than confidence and loving support. Bottle-feeding by the clock will never match the benefits of self-regulated breastfeeding.

Some members object to setting ideal standards, protesting that the prime goal should be to support women as free agents in their choice of services--if a woman has chosen a particular course then it is ideal for her. But we must look closely at what choices are open to her, and whether her choice can ever be freely made. The range of options is always limited: Martin Richards has compared the goal of 'choice in childbirth' with allowing a woman to select from the supermarket shelves either Birds Eye or Findus fish fingers, when the real issue may be to find somewhere that sells fresh fish.

And our choices--what we think we want--are necessarily influenced by our culture. The predominant cultural message in obstetrics is one that is completely contradictory to a woman being in control, making her own choices. While midwifery is the female art of watchful assistance of a woman's own efforts, obstetrics is the male business of having the baby for her, diminishing her from a creative life-giver to a passive vessel. Giving birth is a powerful act--so powerful that it has been hypothesized that male oppression of women springs from deep fear of women's power in giving birth--and obstetrics obliterates that power, taking control away from the woman.

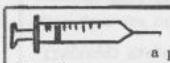
But if some women want the experience of actively giving birth taken away, should we not support that choice? We must remember here the enormous pressures on women in making 'choices'. A historical look at 19th century gynaecology and obstetrics--the forefather of today's practice--is enlightening. Our great-grandmothers were told by their culture that they were to have no sexual desires, and that womanhood's purity rested in feeling no urges for sexual expression, which were linked with insanity, disobedience, and the breakdown of society. Women believed this--so much so that many became rigidly unable to have sex; gynaecologists in America made a practice of visiting wealthy homes to anaesthetise women for sexual intercourse, to allow them to become pregnant. How, we might ask, is anaesthesia for conception related to anaesthesia for birth? Have those women today who feel unable to give birth without drugs not been as perversely influenced by their culture as were their foremothers? A further example: when it was the fashion to remove the ovaries of women who suffered sexual desires, were disobedient, etc., thousands of women were so castrated; women came to doctors begging for this operation, and expressing their profound gratitude and relief afterwards. Would we feel obliged to support their right to castration, to represent the 'choice' women were making?

We are reluctant to impose our position on other women. But we must recognise that women are already imposed upon, that their choices are not free. It would be unfair of us to tacitly accept the cultural weight on their decisions, without telling women what we have learned about the damaging effects of current practices. In the end, we must always recognise the woman's right to choose--and must support that legal right whether or not we feel her choice is wise--but we owe it to her to help her find the way out of the cultural limits, and to embrace her full potential as a woman giving birth.

There is some concern that if AIMS were to develop a defined position in favour of non-intervention in normal birth, our effectiveness as a pressure group would be lessened. Decision-makers would write us off as a fringe group, as 'cranks'. This fear is probably exaggerated: our public image already is 'anti-technology', and our credibility does not suffer if we continue to back up our arguments with sound reasoning and documented facts. And our effectiveness as campaigners is enhanced if we have a platform to work from, an ideal to promote, rather than just reacting negatively to issues as they arise. We could begin to make positive proposals to develop excellent services fostering healthy, satisfying child-bearing.

'Choice' is not enough. It is time we recognised that it is not really a valid priority in improving women's experiences of birth. We praise Michel Odent and Ina May Gaskin--but there is no 'choice' at Pithiviers, or The Farm. It is time we established our ideal as a yardstick against which to measure existing provisions, and actively campaign for services in harmony with and support of that ideal.

-- Nancy Stewart.



"For most women labour is a painful experience and it is therefore necessary to seek effective methods of relieving pain during this important experience in their life...One of the drugs that has stood the test of time is 'pethidine'...it has probably enabled countless thousands of women to have a somewhat less distressing labour experience than they would otherwise have had to endure."

--Editorial, 'Midwife, Health Visitor & Community Nurse' April '82 (the editor is an obstetrician)

"Pethidine is the worst thing you can give to women in labour. Pethidine doesn't relieve pain. It makes you nauseous, it makes you sleepy, it makes you stupid, and it makes you placid--and you don't want to be any of those things when you're in labour. If you want to help the childbirth situation in this country, start advising the women not to accept it."

—Ina May Gaskin, midwife
Oxford Birth Centre
16.5.82

References

1. Thaler, R.H. & Sunstein, C.R. (2009) Nudge. Improving decisions about health, wealth and happiness. London: Penguin Books.