CHAPTER 1

The context of choice in pregnancy and childbirth

The dominant medical philosophy of management of women in pregnancy is that pregnancy is a condition that can only be considered normal in retrospect and in labour is primarily focussed on the efficient and safe removal of the fetus from the mother.[1] In this context problems are not only solved but defined by experts with specialist knowledge, with the experts traditionally being medical practitioners.[2] This medicalised and risk averse approach has resulted in a high value been placed on detection of abnormality, defining all women, not just those with potential complications, as needing hospitalisation and medical surveillance and input. However, such a framework also resulted in a workforce of medicalised midwives.[3] Despite more recent and innovative changes in the way midwives deliver care to pregnant women, many midwives continue to work in obstetric technology driven units, creating an obstetric ideology that Nadine Edwards refers to as coercive, suggesting that while minor choices exist, conceptual choices do not.[4] It is unsurprising in such a context that issues surrounding women's personal control and choice in a childbirth context were, until relatively recently, viewed as of secondary concern and a labouring woman's perspective was often not acknowledged during childbirth by the clinical staff determining her care.[5]

THE POLICY CONTEXT

Improving the experience of childbirth for women was nationally prioritised through Changing Childbirth,[6] the report prioritised individuality of women's needs, their need for information, involvement in planning care, an ongoing relationship with a lead professional and accessibility of services. The three central tenets of that document were choice, control and continuity. Changing

Childbirth was a product of the wider strategic healthcare reforms of the 1980s and 1990s, a politically determined attempt to make healthcare services more market orientated and consumer driven. The document emerged directly from the House of Commons Health Select Committee Maternity Report,[7] which had concluded that maternity care should no longer be driven by a medical model of care. The Changing Childbirth document clearly reflected the views of consumers as well as professionals. The aims of the document were to be achieved within a bold five-year timescale, and a number of pilot schemes emerged in an attempt to meet the policy doctrine. However, despite success in meeting their intended aims very few of these schemes were enduring in nature, in a large part linked to cost and a failure to find recurring funding, leaving both consumers and midwives disheartened and cynical. The Changing Childbirth document was however a seminal one and the forerunner of subsequent and current policy. Whilst policy language has evolved since the early 1990s, continuity appears to have become 'women-centred care' and new words such as 'flexible' and 'accessible' have entered the rhetorical arena, choice remains a popular word within political vocabulary. Documents such as the National Service Framework, Maternity Standard 11[8] and Maternity Matters[9] lucidly illustrated choice as an integral part of contemporary maternity care. Maternity Matters stressed 'a wider choice in maternity care' and laid down choice guarantees (p. 5), which included choice of how to access maternity care, type of antenatal care, place of birth and postnatal care. Unlike its predecessor Changing Childbirth, the implementation of Maternity Matters was accompanied by a monitoring framework, which was included in the document.[9] However, recent healthcare reports and reviews[10] suggest that many trusts are falling well short of these targets.

Maternity policy under a labour government has reflected wider government policy in relation to a contemporary NHS, including the recent Darzi report.[11] Although Darzi said little about maternity care in particular, it did comment on the need for a more personalised NHS, responsive to each of us as individuals, giving us real choices over our care and our lives, commenting specifically that women want greater choice over place of birth.[11] Despite a change of government, the most recent publication 'Liberating the NHS', sees the rhetoric of choice for women within maternity services persist, with the continued recognition that any choice offered needs to be informed and safe (p.17).[12]

WOMEN AND CHOICE

As evidence for some time has pointed out, women themselves appear to desire choice in maternity care.[13] Women state that they would prefer more choice about the type of care and site for delivery.[11] A postal survey identified that a large

minority of women (46%) when assessed antenatally and postnatally did not feel that they had exercised informed choice overall in their maternity care. Of particular interest is that informed choice differed by decision point and whilst it was reported as high for decisions such as screening for Down's syndrome and spina bifida it was low for interventions such as fetal monitoring in labour, which are more likely to be determined by professional perceptions of risk.[14]

Choice implies both knowledge and understanding, and assumes that individuals make choices based on wants or needs and the ability to assess and dismiss alternatives. It is suitably acknowledged that choice is not an equitable concept, low income, poor housing and nutrition are all inequalities recognised to restrict access to services, increase risk[8,9] and consequently decrease choice.[15] Kightley highlights the increase in female headed lone-parent households and suggests that in such households the choice of a hospital delivery may be a choice for support, that a woman might not otherwise have access to because of her single status, rather than a choice for the type of birth experience she would prefer.[16] It is important to recognise that women make choices for a whole set of often complex reasons and it should not be assumed that the decision to have a hospital birth is the wrong one.[16] However, we also know that choice is constructed through pervading belief systems and resources[4] and the recent Birth Place Choices study demonstrated that the majority of women, continue to cite hospital 'as the best place to give birth' and make choices according to the continued social construction of hospital as the safest place for birth.[17] Kightley further suggests that in the UK, hospital birth can be seen as the birthing tradition of many indigenous women of childbearing age, a legacy from their mothers who were told and believed that hospital was the safest place for them and their babies.[16] This potentially creates tensions for women between a desired birth experience and the need to be seen to make responsible and safe choices. Safety is a key issue in maternity care and despite the fact that childbirth has never been safer, in terms of mortality, fear of birth amongst mothers remains,[18] recently highlighted by the new diagnostic category of tokophobia (morbid fear of labour). Fear is also an influential factor in terms of the professional culture surrounding maternity care[19] and relevant here is the risk discourse surrounding pregnancy, which will be discussed in more detail in Chapter 2.

MIDWIVES AND CHOICE

The Royal College of Midwives has consistently supported client choice with regard to the place of birth, and encourages midwives to offer choice.[16] Studies demonstrate, however, that midwives restrict information to certain groups of women, depending on risk assessment and their own personal experiences.[17]

Edwards suggests that there are differences between midwives individual ideologies and the ideology of the system within which they practise.[4] Such findings ask fundamental questions of the Maternity Matters choice guarantees. The document itself states that 'Choice is dependent on circumstances' and 'for some women, team care will be the safest option'.[9] Within such a model, options and choices for those women identified as 'high risk' are immediately constrained and a desired pregnancy and birth experience becomes secondary to perceptions of risk and concerns about safety.

A choice framework assumes a democratic model, where the woman is expected to be able to exercise her rights and make choices.[3] However, much of the information is held and its nature determined by healthcare professionals, as such decisions are not made from a level playing field.[15] Women are entitled to make informed choices about any aspect of their maternity experience they want regarding place of birth, type of birth, pain relief in labour and method of feeding, to name a few, as long as it is the choice we, as professionals, think they should make. A system of rights based on guilt and blame is unlikely to create a context in which women can assert their own knowledge, desires and need. Examples exist of women's negative experiences when they have declined professional advice and made a choice for an unadvised course of action.

> [A]nd I said look at the end of the day it's my right to choose a home confinement . . . this is what I want and this is what I'm happy with. And she said well I don't think I can support you in this decision. In my opinion I think you're making the wrong choice. I don't think home is the right place for you to have your first child. You don't know what its going to be like. You don't know what complications you are going to have and goodness knows anything could go wrong and you know you could end up putting yourself and your child in danger. Do you want your unborn child to die? . . . It left me feeling very isolated . . . you end up with self-doubt – whether you are making the right decision or whether you are strong enough to actually go the whole way with it (p. 16).[4]

Very few women, of course, go against professional advice; most women will not make choices that they perceive might alienate those providing them with care. The Royal College of Midwives , comments that women tend toward compliance when they perceive that they or more especially their baby is at risk.[20] Studies have demonstrated that experts in the form of medical and midwifery personnel continue to be viewed by women as knowing best and as such play a vital role in constraining or facilitating women's choice. The gatekeeping role played by some GPs in both facilitating and impeding choice has been demonstrated, and whilst women who experienced barriers to choice expressed discontent, the

GP remained fundamentally unchallenged.[21] Midwives have also been accused of being complicit in ways of working and advising that incorporate a medical model.[3] Weaver demonstrated how midwives through their own personal opinions represent home birth as hazardous to women, which in turn leads women to express similar fears.[22] The legacy of the medical model, with depictions of pregnancy and birth as a risky process, continues to emphasise hospital and expert intervention as the means to assure the safety of the baby, which constrains women's choices through fear.[21]

Guideline-driven care standardises clinical behaviour, and further reinforces a right course of action or choice particularly when deviation from the pathway requires written justification.[23] Such an approach fails to support midwives autonomy and in turn compromises the midwives ability to facilitate women's autonomy. Risk protocols and evidence based care are seemingly often incompatible with choice. Hollins-Martin and Bull further demonstrated how midwives feel obliged to obey a senior midwife and when conflicts arise the obedience to the senior person is prioritised over being an advocate for a women's choice.[24,25] Many midwives experienced impediments to their ability to provide and support women's choice. These included hospital policies, hierarchical control and fearing consequences of challenging senior staff, which in turn comprised of fear of an abnormal obstetric outcome, litigation, conflict and intimidation.[25] It should be acknowledged that senior staff are also part of a hierarchy and within that hierarchy are expected to implement standardised procedures and guidelines. In this position they may also find supporting choice difficult.[26]

It is important to emphasise that whilst it is well documented that midwives can constrain women's choices through their attitudes, beliefs and the inherent power balance in the relationship, many midwives actively seek to support women's choices despite difficult circumstances and often being uncertain about outcomes themselves.[27]

BENEFITS OF CHOICE

Limited research evidence has evaluated the benefits of choice for women in maternity care. Maternity care choices have been linked to maternal satisfaction[28,29] and personal control.[18,30] One framework through which the benefits and detriments of choice have been discussed is autonomy, and Nadine Edwards claims that decreasing autonomy risks decreasing women's sense of self-worth, self-trust, self esteem and confidence, and further may undermine the self.[4] This suggests that when women are enabled to be autonomous that there are significant associated psychological benefits. However, the choice of maternity

care, as a single independent variable does not, it seem, lead to the psychological benefits expected.[31,32] Indeed, findings suggested that women experience similar physical and psychological challenges across the maternity spectrum, regardless of the choices they make for care.[31] One of the key difficulties is that woman make choices for maternity care with no real knowledge of what is ahead in pregnancy and choices made can become impossible to fulfil if the 'risk status' of the pregnancy changes and decision-making regarding the pregnancy and or birth then inevitably becomes remit of the experts rather than the woman.[21] Further explanations for a lack of empirical evidence to support the psychological benefits of choice are that choice is simply not a reality for women, it is an illusory concept with lip service featuring prominently,[33] and more likely rhetorical to the point of non-existence.[34] The limiting of women's autonomy and the controlling of choices by practitioners makes it impossible for a woman to make true choices,[34,35] making associations between choice and outcomes impossible to determine. Whilst such claims seem to provide an intuitive interpretation of the quantitative element of our study, it is also possible to propose that women across the groups were satisfied with the choices made and so choice had indeed led to psychological benefits. Such an interpretation, however, is undermined by the psychological profiles displayed by women across the groups. All women worried about socio-medical aspects of pregnancy with worries highest in late pregnancy, further the findings in relation to control suggested that in pregnancy women believe that 'powerful others' (which would include the midwife as well as the doctor) have control over events governing their health but more illuminating is that this increased external control appears to compromise women's internal control.[31] This latter finding might make it feasible to suggest a further explanation, which is that the positive outcomes credited to choice are rather associated with issues of control. The issue of control will be discussed in more detail in the next section

Choice has been a policy theme notoriously hard to fulfil. Fifteen plus years on from Changing Childbirth, evidence suggests that fundamentally little has changed,[36] and the 'reality of choice' remains elusive despite the continuing official focus.

CHOICE AND CONTROL

Shelia Kitzinger acknowledges that 'the debate about control is challenging because there is little agreement about what the word means' (p. 12).[37]

Evidence seems to suggest that the constructs of choice and control are intimately connected for women with regard to pregnancy and their childbirth experience. The opportunity for greater choice over care allows more

involvement with decision-making and impacts on a woman's feelings of control. In a study by Walker, women choosing delivery in a midwife-led unit formulated a very clear idea about the type of experience they wanted for the birth of their baby and loss of choice was found to be an important reason for feelings of loss of control.[38] In her study exploring women's experiences of home birth, Nadine Edwards illustrates how technology can cause women to feel a loss of control.[35]

> I did feel (in control) unless I was strapped onto the monitor and then it really changed me. So no, I didn't feel very much in control then but when I was doing all my different positions I was completely in control (p. 232).[35]

Gatrell's work with professional women demonstrated the physical and mental affects for women when they felt deprived of choice and information. Whilst women did not object to medical intervention per se all women found it difficult when it robbed them of a sense of control during pregnancy and birth. Also noteworthy in that same study were the, albeit small number of women (n=3) who reported depression for up to three years following a perceived traumatic birth, seemingly exacerbated by the feelings that they had lost any sense of control during pregnancy or birth.[39] These women suggested that loss of control had robbed them of self-confidence and self-esteem in all aspects of their lives for a considerable time. Such interpretations are consistent with Green, Coupland and Kitzinger,[18] who, in their large study examining the psychological effects of childbirth on mothers, found that the perception of feeling in control was reliably and consistently related to positive psychological outcomes. Other studies have concurred with these findings. Lavender, Walkinshaw and Walton revealed control to be amongst the themes contributing to women's views of a positive birth experience.[40] A study by Schneider using a qualitative framework found that control emerged as an important issue even in the first trimester.[41] Studies have identified that women seem to judge most situations by the degree of control they feel they can maintain.[42] Maushart, however, suggests that it is the illusion of control over their bodies that is important to women,[43] and Green and Baston propose that women are more concerned about negotiated levels of control and that any surrender of control is voluntary.[43] Women themselves are not always clear what they mean by control; control can relate to many aspects of pregnancy such as behaviour, decisions related to her pregnancy, control during labour and delivery, or control over the course and direction of her pregnancy. Women may demonstrate awareness of the changes that are happening in pregnancy, and feel conflict as a result of the difference between their self-perception of being in control and discomfort as a result of those things 'just happening to

their bodies'.[41] This may leave women feeling a loss of control reinforced by their inability to relieve the physical symptoms of pregnancy, labour and birth.

Personal perceived control has been found to be an important determinant of women's satisfaction with their birth experience.[44] Personal control has been found to be dependent upon pregnant women having options that allowed choice, adequate information and involvement in the decision-making process. It is suggested that a midwife is the professional best placed to provide access to adequate information,[45] and so women receiving midwifery-led care might be expected to demonstrate greater levels of personal control. A study of women with negative memories of their first birth having a subsequent home birth, found that women felt able to exercise control over their subsequent deliveries due to the role of the caregiver, who enabled them to overcome personal characteristics including low self-esteem and obedience to authority.[46] However, Edwards exploring control in the context of women choosing and planning homebirths, found that whilst women initially felt that staying at home to give birth would enable them to remain in control, in reality they found the picture once again to be much more complex.[47] Whilst women could establish and maintain control over the environment, control and decision-making more broadly were dependant on similarity between midwives and women's views and beliefs, and the medicalised technocratic model often shaped information exchange and hence decision-making and control.[47] Edwards comments sadly that this reflects the findings reported over two decades earlier.

Choice and the notion of subsequent control are dependent on information gathering relevant to that woman's individual circumstances and entrusting her to make decisions. The rhetoric of choice and control offers a promise of autonomy for women but studies conducted using qualitative research methodologies have highlighted a loss of personal autonomy and control as a key theme for women during labour and childbirth.[35,48] Eakins, focusing on women who conceptualised childbirth as non-medical, found that they rejected the institutionalised hospital system in favour of attaining personal control; participants in postnatal interviews cited feeling in control as their most preferred aspect of the experience of labour and birth.[49] Cunningham found women choosing birth-centre and home births nominated the desire to have an active birth with control.[50] However, for some women control is conceptualised differently and may be linked to the 'safety net' of the hospital. In contrast to many other findings, a study investigating home versus hospital management of women with a pre-labour rupture of membranes, found women in the hospital group displayed higher internal locus of control (LOC) scores than those in the home group at the onset of labour or prior to induction of labour.[51] This suggests that those women in the hospital group actually felt more in control of events

governing their health at that time. Whilst this may seem counter-intuitive in light of other evidence, one potential interpretation of these findings is that they reflect the medical and technocratic discourses that surround birth and with which women are presented. Brewin and Bradley investigating women's perceived control and the experience of childbirth did find that women who perceived themselves to be in control over their labour reported less pain, however, interestingly, less pain was also reported when they perceived the staff to have control over their labour.[52] Anderson suggests that the worst option for women seem to be when they believe that no-one has control over the labour and for labour to be 'out of control'.[53] Labour is inevitably a process where loss of control can occur and one solution to a feeling of loss of internal control is to seek external control. Gould suggests that when we believe things are out of our control we develop a fatalistic attitude.[54] This may proffer some explanation as to why generally women are overwhelmingly complicit with a handover of control during pregnancy and birth because to resist may compromise a safe outcome and the well-being of their baby.[21] What is clear is that the conceptualisation of control in pregnancy and childbirth is more complex than some of the literature has previously assumed, as is its relationship to choice.

More recent psychological studies have implicated the domain of personal control, in particular, low levels of perceived personal control, as being related to experience of post-traumatic stress symptoms following childbirth.[55] The authors suggest that developing care interventions that enhance perception of control has been suggested as a possible intervention to reduce the possibility of post-traumatic stress symptoms post-partum.[55] Scott-Palmer and Skevington found that women with an internal LOC orientation (women who felt more in control of events governing their health), had significantly shorter labours compared to women with an external LOC orientation (women who felt their health was governed either by chance or powerful others).[56] Tinsley and colleagues found that perceptions of personal control were associated with compliance to prenatal health regimes, which in turn were related strongly to actual birth outcomes.[57] This suggests that control during pregnancy and birth has far-reaching implications beyond those of satisfaction with care or experience.

The mother to be's perceived uniqueness of the experience of labour and childbirth has also been identified to influence LOC orientation. Lowe found that high levels of fear and apprehension regarding a forthcoming confinement were significantly associated with high levels of 'chance' and 'powerful others' health LOC.[58] Accumulating evidence seems to suggest that perceived control does interface with the psychobiological process of the woman's childbirth experience. As referred to above, the findings from the quantitative arm of this study[31] strengthen the claim that pregnancy per se compromises internal control. Pregnant women

as a group demonstrated higher scores as measured by the Multidimensional Health Locus of Control Scale [MHLC[59]], 'others' (would include midwives), doctors and chance subscales, and lower scores on the internal subscale than non-pregnant counterparts. This suggests that women perceive internal control as compromised and their health as much more externally controlled, particularly in medical terms. This may not necessarily be a negative finding and other authors have demonstrated that control was rather related to how women perceived they were treated and consideration of caregivers was significantly and positively related to feelings of control.[30] The women's narratives presented later will provide a more nuanced perspective of the concept.

SUMMARY

It is acknowledged that childbirth represents a major transition in a woman's life and serves as a 'rite of passage' into the social institution of motherhood. Birthing is both a physical and psychological challenge and the manner in which a woman experiences birth is likely to affect her adjustment to motherhood.[60]

There is a clear and official focus and rhetoric of woman-centred childbirth, and choice and decisions about their care are an integral element of that rhetoric. Whilst policy changes imply a move away from a paternalistic and controlling model of childbirth to one that promotes autonomy, choice and control for women, robust evidence as to such a change and the tangible benefits of choice for women are lacking. Choices for some women are not a reality; other women may not always be clear about what it is they are choosing, and health professionals have been identified as often culpable in directing women's choices either through the information given or through not giving information at all.

Information-giving, choice, decision-making and control appear implicitly intertwined with a woman's pregnancy and birth experience, and increasingly compelling evidence suggests that it is an interaction between these variables that has significant implications for woman and their maternity experience. Women themselves, however, whilst desiring choice, are influenced by the powerful cultural discourses that surround maternity care. This will inevitably impact on the choice and decision they make.

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