Women still feel like they aren't listened to when they give birth: Here's what could help change things

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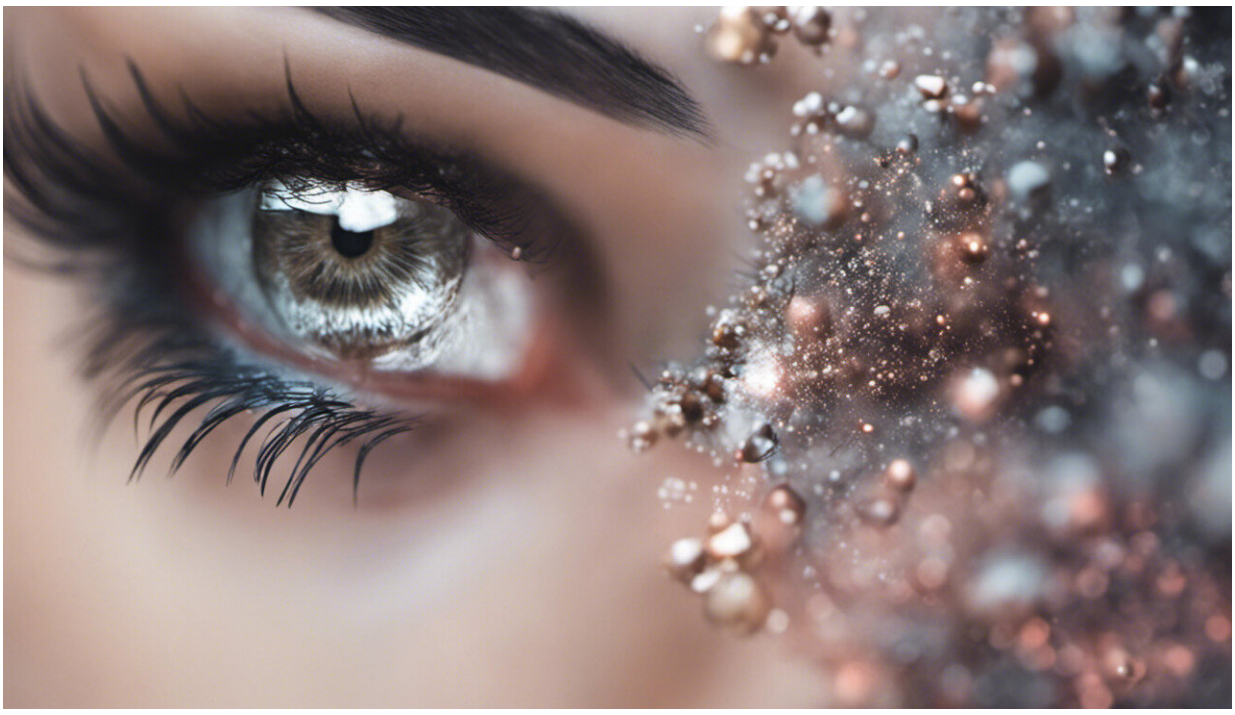

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Women often report that they are not listened to or given choices about what happens during their own labor. But studies have long shown that feeling heard and having choice during childbirth enhances women's well-

being.

These findings led to changes in NHS policy and guidelines beginning with the landmark report Changing Childbirth in the 1990s.

However, our recent research has revealed a disconnect between policy and the reality of how decision making happens. This could help explain why women still say they feel ignored when they ask for pain relief during labor.

Our team of sociologists and midwives examined 37 video or audio recordings of labor and birth in English midwife-led units (where midwives support low risk births).

Although the women wrote that they expected and wanted to be involved in decision making when they went into labor in pre-birth questionnaires, this generally didn't happen on the day. Nevertheless, when many of the mothers filled in follow-up questionnaires about six weeks after birth, they mostly reported being satisfied with their experience.

However, some women faced various forms of resistance from midwives about pain relief over a long period of time and were less pleased with how things went.

A key limitation of our study is that the 36 of the 37 mothers in the study were white. This is important to note beacuse black and Asian women in the UK are more likely to die in childbirth than white women.

Complexity of pain relief decisions

No one should be denied pain relief without explanation, but our study findings show how complex decisions about pain actually are.

For example, increased pain is a sign the woman may be close to delivering her baby. If women take opiates during the second, "pushing" stage of labor, there is a chance the baby could be born with opiates in their system, which sometimes means newborns need help to start breathing. It can also interfere with breastfeeding.

One woman, who we called Fiona, requested opiate pain relief 18 times over an hour and a half. A key issue for Fiona was a shift change, shortly after an agreement to administer pain relief depending on the outcome of a vaginal examination (to check that Fiona was not "ready to push baby out").

The outgoing midwife left before conducting the examination and Fiona reissued her request for opiates almost as soon as the new midwife entered the room. The midwife asked what form of pain relief Fiona had in her previous labor and the nature of her current pains. Then she asserted a need to conduct clinical observations (such as blood pressure).

Nevertheless, the midwife kept the matter open by saying: "Bear with me and then we'll keep having a bit more of a chat about your options." The situation continued to unfold in this way, with Fiona requesting opiates and the midwife deferring the decision.

It was some time before the midwife outlined the risks involved with opiates.

Fiona hesitated but agreed to forgo opiates and delivered her baby around ten minutes later. In her post-birth questionnaire, Fiona said she did not regret going without opiates but added,

"I don't feel that the midwife in the later stages of my labor listened to what I was saying. All in all the experience was positive. However, I asked for increased pain relief around 6.30am and repeatedly after that,

and the midwife did not have a discussion with me about why it would be advisable not to have the pain relief until around 8.20am. In the meantime I was very frustrated that no one was listening."

Midwives lead most decisions

The way a person initiates a conversation can open up or close the opportunity for the other person to participate. For example, a pronouncement—saying that something is going to or needs to happen—conveys that the decision has already been made unilaterally.

When midwives made an offer (such as "do you want me to give you a bit of a massage?" and gave option-lists, on the other hand, they set up an opportunity for women to make a choice. When we examined how midwives initiated decisions, the majority (57%) were unilateral. But this is not necessarily a bad thing.

Pronouncements occurred a lot in relation to fetal monitoring. For example, midwives saying "I'm just going to listen to baby, lovely." These declarations place little pressure on women to respond, and the frequent use of "just" conveys that monitoring will involve minimal disruption.

The value of routine vaginal examinations is contested among researchers. However, NHS guidelines state they should be offered every four hours in the first stage of labor.

Midwives did occasionally offer explicit choice about whether a vaginal examination should take place, but only in early labor when they suspected there was no progress. Otherwise, decisions about examinations tended to be pronounced, but always involved an explicit consent check beforehand.

Overall in our recordings, birth partners typically deferred to midwives and confined themselves to providing support for their partners.

In the third stage of labor (the time between the baby's birth and delivery of the placenta), the cutting of the cord is the only moment where birth partners—fathers in our dataset—were treated as decision makers.

Midwives routinely offered birth partners the opportunity to cut the cord. While women in our study did not seem to mind, there are potential conflicts between involving fathers in pregnancy and birth and maintaining women's bodily autonomy.

The difficulty of providing choice

Our findings illustrate how difficult it is for midwives to promote patient involvement in a context where guidelines and clinical knowledge indicate particular things should happen.

The fact that the length of labor is inherently uncertain does not help. We suggest that midwives would benefit from better support and training to manage these tensions and that it would be helpful if these conflicts were recognized more explicitly within policy.

Our findings also highlight the need to improve communication during decisions about pain relief. Delaying or deferring decisions can leave women feeling unheard during one of the most, if not the most, vulnerable times of their lives.

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