Do birthplans empower women? A study of midwives' views


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Last week, we explored women's views of whether birthplans empower them in the birth process. This week, the second half of the study is presented. It explored the perceptions of empowerment from ten midwives, using the birthplan as a tool. Data were collected by semi-structured interviews. The findings indicated that several factors could disempower the women as well as the midwives. For women to be empowered, midwives need to provide open communication, adequate life skills, a nurturing and caring environment, and a democratic management structure. Advocacy and paternalism were found to be constraining factors for empowerment.

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KEY WORDS

- Midwifery
- Women's rights
- Patient advocacy

These key words are based upon work undertaken by the RCN Library.

Birthplans are used in an attempt to demedicalise the birth process and empower women during childbirth (WHO 1985). The use of birthplans was strongly endorsed by the Second Report on Maternity Care in Action (1984) as a way of negotiating individual needs during labour. Since then, use of the birthplan has become a common practice, particularly in maternity units where care is fragmented. Midwives have incorporated birthplans during labour and used the discussion as an opportunity for getting to know the women and understanding their needs. The birthplan is in effect a negotiated management plan of labour and delivery.

This radical change in midwifery practice marks the shift of power from midwives (and doctors) to women, and from a paternalistic medical model of care to a more humanistic approach to childbirth. The use of birthplans has improved relationships between women and midwives, thus making the midwives' role more rewarding (Crooke and Smith 1988). However, using the birthplan as a strategy in intrapartum care and the consequences for midwives of empowering women have not been empirically substantiated.
AIMS AND METHOD
This study aimed to explore the perception of empowerment from ten midwives, using the birthplan as a way of investigating the process of decision making, choice and control during labour. Data were collected by semi-structured interviews from a randomly selected sample of midwives. The characteristics of the midwives are summarised in Table 1. This paper will discuss only the issues related to the main findings raised from this small study.

PERSONAL BIRTH EXPERIENCE
Midwives' personal experience of childbirth revealed similar findings to the women in the first part of this study (Too 1996). Six midwives had lasting memories of their unpleasant experiences many years ago. The conversation included references to events which were highly personal, emotionally charged and unresolved. They experienced despair, frustration and helplessness in the hands of medical control and unsympathetic midwives with descriptions such as: 'Nightmare'; 'I was left on my own'; 'They were in charge of my body'; 'I had no say. I didn't have a choice'; and 'I was told to lie on my back and get on with it'. However, midwife Lily who had a 'domino' delivery and Catherine who had two home births by the community midwives, described their birth experiences as 'wonderful, satisfying, fulfilling' because their midwives were 'caring, supportive, understanding'.

Two midwives who did not have children indicated that although personal birth experience gave insight into the birth process, sensitivity and empathy were essential elements in assisting women in labour. There is no evidence to suggest that midwives who have experienced childbirth themselves are necessarily more empathetic.

PHILOSOPHY OF MIDWIFERY CARE
Midwives in this study reported that they viewed women as unique individuals having dignity, freedom of choice and intelligence. They perceived them as partners-in-care, having a central role in the assessing, planning, implementation and evaluation of care. These midwives believed that each birth should be made as fulfilling an experience as possible for the woman and her family. Their professional ideology encompassed providing holistic, individualised care. Midwives in this study chose midwifery as a career for various reasons. A majority of them found helping women in their birth process the most rewarding experience. Not being able to offer effective choices, and the use of obstetric intervention in normal births were among the most disliked aspects of their practice. Some of them, based on their unpleasant birth experiences, acted as catalysts for change. Midwives' birth experiences had given them a critical awareness of the problems associated with childbirth and a readiness to improve the maternity services.

BENEFITS OF USING A BIRTHPLAN
All midwives were familiar with the use of birthplan. Tables 2 and 3 summarise the midwives' perceptions of the benefits of using a birthplan for women, and for themselves. Midwives also indicated that they would adopt a flexible approach to labour, without compromising safety, to provide a more 'natural' birth process for the majority of women. It was their belief that choices should be kept open.

MIDWIVES' VIEWS ON WOMEN MAKING DECISIONS AND EXERCISING CONTROL.
Although all midwives in this study agreed that women should be allowed to make decisions and have control, there were differences on the extent to which the women should be allowed to make decisions.
Kate said: 'To enable them to make decisions and informed choices, midwives should discuss the implications such as the effects and side-effects of analgesia...If not, it would become an unbalanced power game with the women demanding what they want and the midwives dictating to the women what they should have.'

Lily, having been a midwife for three years, believed that some women were incapable of making rational decisions and they must have decisions made for them for their own good: 'I wonder whether they can take the full facts, advantages and disadvantages and all that...Will it do them any good to worry about something they don't understand?...You just don't have the time...Anyway, some women expect you to do what is best for them.'

Lily considered her primary duty as that of causing the women no harm and disclosure of adverse information such as 'disadvantages' would breach this duty. She assumed the role of advocate for women who were reluctant to express their wishes. In fact, the advocate role had legitimised her paternalistic approach to make decisions on behalf of the women in their best interests. Lily also illuminated the conflict between caring and empowerment. The perception among the public of midwives as 'doers' rather than 'enablers' still holds firm.

Four midwives said that because of the time constraints and lack of staff, it was often quicker to decide for the women than to go through the lengthy process of dialogue and negotiation to find a way for action which respected the women's wishes.

All midwives in this study maintained that the administration of pethidine covertly ensured the women's acquiescence, making them unable to take control. Hope summarised this view: 'Once pethidine is given, the woman is not capable of making decisions for herself...The control is transferred to the midwives.' This reference was supported by the women in the first article (Too 1996) that the use of pethidine was seen as a tool to disempower the women.

STEREOTYPING IN RELATION TO THE USE OF THE BIRTHPLAN

Based on their own observation, midwives in this study perceived the existence of two groups of women in terms of the use of birthplans. The 'interested' group of women were those who were well motivated; had attended parent education classes; were first-time mothers; or were involved with the National Childbirth Trust. According to the midwives, these women always had a birthplan.

The 'disinterested' group of women included the multiparae; the teenagers; the less educated; the lower socio-economic groups; and those who had total trust in the midwives. According to the midwives, these women tended to abdicate all responsibilities and they were unlikely to have a birthplan.

These assumptions were affirmed by Green et al (1990) who found that midwives rely on stereotypes to help them interact appropriately with women and to make assumptions about what women want and what is good for them, particularly when the labour ward is busy and midwives do not have the chance to get to know the women before or during labour.

In conclusion, Faith advised: 'The quiet ones doesn't mean "don't care less". We should find out the reasons. Perhaps it is their nature. They may be as knowledgeable and well read as the articulate ones...Whatever their orientations or wishes, it should not preclude individual rights in choosing what they want or don't want...The more they are encouraged to make decisions themselves, the more self-reliant they become in taking responsibility for their well-being.'

facilitating FACTORS

Midwives in this study identified the following factors that midwives could use to enhance the process of empowerment:
• Accept women as individuals having diverse needs
• Respect women's wishes within confines of safety
• Be aware of own feelings and prejudices
• Be willing to relinquish control
• Give information freely
• Be able to communicate with women at appropriate level so as not to patronise or overuse medical jargon
• Find time to give guidance and discussion
• Know what available options in health district are
• Have confidence in own professional practice and judgement
• Maintain continuity of care as far as possible
• Have commitment and courage to change
• Work with the women in the assessment, planning, implementation and evaluation of care
• Ensure the caring environment is non-threatening.

The attitudes of midwives play a central part in the empowerment process. The following attributes were described as important: sensitive to the needs of women, empathetic, calm, supportive, approachable, kind, friendly but professional, non-judgmental, non-authoritative, non-aggressive, confident, honest, willing to listen, and flexible. These attributes were the same descriptions identified by women in the first part of the study.

Mutuality and reciprocity were other important factors, as Felicity highlighted: 'Most of all, the women must be ready and willing to take responsibility in decision making. They must trust, respect and have confidence in the midwives.'

CONSTRaining FACTORS

Midwives expressed their concerns that there were constraints related to the women, the midwives and the organisation of maternity care.

Midwives in this study believed that the women's educational levels determined their motivation to seek information and make decisions during labour. Having expectations that were too high, or not accepting change of rigid plans were frequently reported. Lily maintained that some women were under peer-pressure and had misconceptions of the birthplan.

Catherine commented: 'Some women have this 'supermother' syndrome. They wanted everything. They expected their wishes to be met but were terribly disappointed when they were not met.'

This comment was supported by Faith: 'The whole thing would become futile if women had unrealistic plans, dogmatic and antagonistic attitudes. These behaviours always marred what should have been a happy event.'

Wendy affirmed that: 'Too rigid a plan could cloud the midwife's clinical judgement...It could be anxiety provoking for the midwife.'

These negative behaviours from the women could undermine midwives' confidence in their ability to act and their self-respect as autonomous practitioners.

Constraints of a hierarchical structure Nine midwives in this study felt some of their colleagues had differing values and preferred to maintain the status quo of 'I know best'. Kate observed: 'Some older midwives are still under the influence of a medical model of care. They like to be in charge because they have years of experience and they know what is best for the women.'

One possible explanation for this could be that these 'older midwives'
were trained before 1985 when midwifery education was controlled by the obstetricians who limited the curriculum to support their values. Moreover, midwives are socialised in a hierarchical environment. Working within the bureaucratic structure of the NHS, some midwives experience dissonance of values but learn to conform to survive. This tendency to conform may be difficult to lose even with the insights and maturity of professional life. Owing to the nature of this study, it was not possible to explore further how prevalent such an observation might be. However, Mary argued: 'Age is not relevant...Receptiveness to change makes a great difference in meeting the needs of the women.'

Organisational constraints At the organisational level, inhibiting factors include fragmentation of care, lack of resources and facilities, staff shortages, and hospital policies and protocols. The following accounts captured some of these issues:

- Mary: 'There are choices and options for women but we only have one birthing room and one waterpool. I can only offer the women on a first come, first serve basis'
- Faith: 'We talk about individualised care. But in reality we don’t have individualised care...The current management is based on saving money and getting things done with minimum staff, especially at night. You can’t help any women properly if you have to look after three or more women at a time'.

Three midwives cited the difficulties they had when women were admitted to the labour ward without a birthplan. They felt admission was not the best time to gain information or negotiate the birthplan. Completing the birthplan with the women on admission to the labour ward became intrinsically administrative rather than participatory: 'There are things to be done on admission. I don’t have the time to explain everything. I just brush the surface to give her enough information...The birthplan is just another piece of paper to be done.' Catherine agreed: 'It is vital that information [on the birthplan] should be given before labour, not when she is in pain.' Rachel: 'Its (the birthplan) use is limited by the hospital policies such as all women are monitored continuously for at least half an hour when they come in... When she (the cervix) is dilated to 3 or 4cm, the membranes are ruptured. We know that research had proved that these procedures are not justified. But they are the policies and protocols of the labour ward.' Kate argued: 'If ARM (artificial rupture of the membranes) is not necessary, I'll discuss with the doctor why the woman does not need it.' Rachel and Kate demonstrated the dilemmas of acting according to the labour ward routines and the recognition of autonomy in the midwife’s role.

Patricia related the lack of support from her managers: 'In order to empower the women, midwives must feel valued. If they feel devalued and dehumanised (depersonalised) or have low self-esteem, it could have a knock-on effect on the women...I often find it paradoxical. We are supposed to be in a caring profession but we are not cared for and nurtured...We badly need staff support and counselling.' Felicity further indicated: 'We don’t have any say whatsoever. We don’t have a lot of autonomy as a profession...No one dares to go against the managers as we might lose our jobs.'

The above accounts illuminated the current position of the midwives within the healthcare system. Midwives have relatively little power and are in a subservient position vis-a-vis managers and doctors. Midwives experience a sense of self-distrust that they might lose their jobs if they opposed their managers. Lack of organisational support undermines the development of empowerment among the midwives.
PROFESSIONAL ACCOUNTABILITY AND PROFESSIONAL AUTONOMY

All midwives in this study indicated that they endeavour to gain and develop knowledge, skills and competencies to meet the needs of the women. They believed that, in order to empower the women and themselves, they must possess up-to-date knowledge and an awareness of current trends in childbirth practices and research findings. Mary, who had not worked in the labour ward for a long time, acknowledged her limits of personal knowledge and skill, and had taken steps to remedy any relevant deficits: ‘Waterbirth is a new experience for me. I need to find out more about it so that I can give the relevant information to help the women to make informed choices.’

Many midwives expressed the view that there were conflicts between women’s choices or desires and acting on their ‘best interests’. Catherine elucidated an incident in which the woman wanted her husband to deliver her baby: ‘She told me that it was approved by another midwife antenatally. I knew it couldn’t be the case. I found it difficult to handle...We compromised to let him put his hands under mine, touching the baby as it was delivered. I went through with him how to cut the cord but won’t let him do it if it was round the baby’s neck. Yes, we compromised. But I insisted on safety of the mother and baby.’

Rachel cited one woman who had requested no episiotomy: ‘I told her I would like to respect her wishes but now that the circumstances had changed...I decided to do an episiotomy to avoid a third degree tear because the baby was ten-and-a-half pounds...I should have the freedom to act in her best interests at the time. She cannot put a restraint on my professional judgement.’

The above examples illustrated not only the professional accountability of the midwives but also the enabling process by which the women could be helped to make informed decisions which were in their own interests. These midwives maintained their professional actions and defended their decisions to intervene decisively in order to ensure a good outcome.

The issue of threat to self-worth was highlighted by Faith: ‘Sometimes I am very disappointed...Some women call me “nurse” instead of “midwife”...They prefer to ask doctors for advice.’

This issue raised concerns on the medicalisation of childbirth which has, to a large extent, blurred the public’s perceptions of the midwife’s role. This finding is reminiscent of an earlier study of the role and responsibilities of midwives (Robinson et al 1983).

Another factor is the bureaucratic organisation of the NHS with its rules to which midwives, as employees, are expected to conform, regardless of their impact on care. The problem is even further compounded by the fact that the hierarchy within midwifery, with its divisions of labour, limits midwives’ ability to make decisions on their own practice (Kirkham 1989).

DISCUSSION

The findings from the ten midwives showed that they had clear perceptions of the use of birthplans. There was an indication that midwives shared a common vision with the women in gaining control in childbirth.

Their philosophy of midwifery care reflected a partnership model of care. However, there were several constraints, both at the micro and macro levels, which could disempower women as well as midwives. Midwives in this study used stereotypes such as the ‘disinterested’ group to make assumptions about what a particular woman was likely to want during labour and delivery. Stereotyping became a tool which midwives used to approach a woman with different wishes. There is, however, an inherent danger that these stereotypes may become a substitute for
communication between women and midwives.
The adoption of an advocate role in acting on behalf of the women’s interests was well illustrated in this study. Although advocacy is a tempting model for midwives, there are, however, problems which could make advocacy an inappropriate practice for midwifery. An advocate is one who believes him or herself to be the expert acting on behalf of the passive, voiceless ‘patients’ (Kohnke 1982). In fostering such a role, the midwife creates dependency in women who are mostly healthy and should not, therefore, be viewed as ‘patients’. They are capable of expressing their wishes in relation to their healthcare needs. The advocate role encourages midwives not merely to take charge but also to take control.

Paternalism, too, is antithetic to empowerment. Paternalistic care enables the midwives to act in the women’s best interests. It implies that midwives know what is best for women. Information is often withheld from women in their own interest. Without appropriate information, women cannot make informed decisions. Undoubtedly, there are times when advocacy and paternalism are required, for example, when a woman is unable to make a decision because of grave illness or unconsciousness. Equally, a woman may request that the midwife makes the decision for her. To go against her wishes may constitute a violation of client autonomy.

If midwives are to promote the philosophy of women being equal partners-in-care, it is incumbent upon midwives to provide the necessary information for women to participate in the decision making process. Midwives who nurture the existing power and control cannot possibly be in a position to empower women or themselves as a professional group. Another issue raised in this study is the midwives’ ability to maintain their professional role. The implementation of hospital policies and protocols conflicted with the midwives’ perception of good practices. To resolve this issue, consideration must be taken of the fact that midwives are accountable for their actions (UKCC 1992). It is vital that midwives are given the authority to make informed judgements and to act on these judgements. They must be enabled to do what they are qualified to do and for which they are held accountable. This entails co-operation and consultation between midwifery and medical hierarchy to define exactly the role and responsibilities of the midwife.

Unless midwives assume a genuine decision making role and become empowered through their work, they cannot empower women. Midwives must be more assertive in what they do for their clients and the midwifery profession at large.

CONCLUSION
If midwives are to subscribe to an empowerment model, a shift in thinking is required. From the health education and health promotion perspectives, the following considerations must be observed:

- Each woman is a unique individual having inherent dignity, intelligence and freedom of choice
- A woman has the right to be given information in order to make informed choices and decisions
- Midwives need to legitimise the beliefs that women are equal partners in midwifery care by including mutual goal setting and decision making
- In order for an empowerment process to occur, there must be mutual respect, trust and shared responsibility between the woman and the midwife
- Midwives need the self-confidence that stems from appropriate
knowledge and expertise. They need self-awareness of their feelings and prejudices.

- Midwives must be willing to relinquish their control
- Midwives are seen as facilitators and resource persons as opposed to providers of maternity services
- To strengthen their ability to empower, midwives need to be valued and empowered
- Finally, empowerment requires open communication, a nurturing and caring environment, a democratic management structure and the support of midwife colleagues or supervisors.

References

Table 1. Characteristics of the midwives (n=10).

<table>
<thead>
<tr>
<th>MIDWIFE</th>
<th>YEARS OF EXPERIENCE</th>
<th>AREA OF WORK</th>
<th>INTERVIEW TIME (MINUTES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kate</td>
<td>8</td>
<td>LW</td>
<td>45</td>
</tr>
<tr>
<td>Lily</td>
<td>3</td>
<td>LW</td>
<td>40</td>
</tr>
<tr>
<td>Mary</td>
<td>5</td>
<td>ANC</td>
<td>35</td>
</tr>
<tr>
<td>Catherine</td>
<td>27</td>
<td>COM</td>
<td>55</td>
</tr>
<tr>
<td>Faith</td>
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<td>LW(ND)</td>
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</tr>
<tr>
<td>Patricia</td>
<td>22</td>
<td>COM</td>
<td>70</td>
</tr>
<tr>
<td>Felicity</td>
<td>12</td>
<td>ANC</td>
<td>40</td>
</tr>
<tr>
<td>Wendy</td>
<td>8</td>
<td>ANC</td>
<td>35</td>
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</tbody>
</table>
Table 2. Benefits to the women.

The use of a birthplan:

- Enhances continuity of care
- Gives women a chance to talk about the options available
- Promotes active participation in the birth process, particularly for those women who are less articulate
- Involves women in their own care
- Encourages women to take responsibility for their own health and well-being
- Serves as an ‘ice-breaker’ or a form of communication for women who meet different midwives in the unfamiliar hospital surroundings

Table 3. Benefits to the midwives.

The use of a birthplan:

- Gives an opportunity for discussion
- Enables the midwife to know the woman’s preferences – especially useful if she is in established or late labour when the midwife has just taken over her care and has little time to discuss in detail what the options are
- Acknowledges the woman’s choices and rights
- Enhances individualised care
- Serves as a form of clinical audit to evaluate effectiveness of care and current trends of childbirth practices

Implications for practice.

1. Midwives need to be prepared for the consequences of women being more actively involved in their care.
2. Midwives should develop skills in empowering and enabling women, thereby respecting their rights and thus making their experiences in childbirth as fulfilling as possible.
3. Midwifery practice must be sensitive, responsive and relevant to the needs of women.
4. Midwives need to be aware of the complex array of social, political, economic and demographic factors that influence maternity services.
5. The midwifery profession must examine the philosophy underlying its practice and be prepared to effect changes that are consistent with the notion of empowerment.

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