What is influencing the way women give birth? A content analysis of focus group and interview data from expectant & recent parents, obstetricians & midwives in Wangaratta.

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Contents

Abstract

Aim

To understand from the perspective of recent or expectant parents and health care professionals what may be influencing the rate of caesarean section in their local rural setting.

Method

Focus groups and interviews with midwives, obstetricians, new & expectant parents using semi structured questioning. Content analysis of transcribed data to reveal themes and relationships.

Participants

3 local Obstetricians, 5 midwives working across the spectrum of care, 7 Pregnant women at various gestation,7 new mothers with babies less than 1year, 3 new or expectant fathers

Setting

A rural Australian setting with an annual birth rate at the local sub regional hospital of around 450.

Results

These pregnant women, recent parents, obstetricians and midwives appeared to share similar views and values on the nature of birth. There was a mutual respect across the groups for the role each plays in achieving the optimal outcome for mothers and babies.

There was almost a universal sense that the increasing rate of Caesarean section was not desirable, however the influence of larger societal shifts rendered any mitigation of the increasing rate outside of their individual control. A tension exists between the premium value placed on a ‘perfect’ child compared to the expectant management of normal labour & vaginal birth.

More work needs to be done on the acceptance of vaginal birth after caesarean section.

Consultation Matrix

	Recently delivered women	New or Expectant Fathers	Pregnant Women	Midwives	Obstetricians	Total
Individual					3	3
Focus Group	1 7 participants	1 3 participants	1 7 participants	1 5 participants		24
Total	7	3	7	5	3	27

Introduction

There is a universal understanding that childbirth for women in developed nations no longer poses the risks to mother and baby that it did a century ago. Industrialisation with its subsequent improvements in family income, nutrition, hygiene, education, contraception and access to professional antenatal care has all contributed to the safety of pregnancy and birth.

While extraordinary improvements in the safety of pregnancy and birth occurred early in the post war period there has been little change in maternal and neonatal mortality/morbidity since the 1980s.

What has changed in the past two decades however is the rate of Caesarean Section (CS). Australia has one of the highest rates of CS of the Organisation for Economic Co-operation and Development (OECD)[1] countries. Caesarean section requires intervention from highly trained surgical teams and prolonged stays in hospital relative to normal birth. The meaning of this change is debated by expectant and recent parents, health care professionals, academics and the media. The rising rate of CS does not discriminate between rural and metropolitan settings.

Will the rate of CS continue to rise and if so what does this mean for rural communities where there is already mounting pressure on the health workforce and system of care? What pressures are influencing the mode of birth?

Background

This work is part of a larger study focusing on the feelings and experiences of pregnant women in a rural community in Northern Victoria Australia.

While caesarean section rates can be explained in part by physical factors such as increasing maternal age and medical conditions such as obesity, diabetes and hypertension, there remains considerable debate surrounding this issue, suggesting further evidence is needed.

Method

Setting

This research took place in regional Victorian town with an annual birth rate of around 450 births. The caesarean section rate for the last three years has been between 30 – 34% (a rise of 10 % since 1999).This compares with an Australian CS rate of 31% [2] of all births- also a rise of 10 % in ten years and compares with the OECD average of 22 per cent[1]. 84 % of all Australian women who have a CS will have another CS in a subsequent pregnancy. [2]

Recruitment

Women were recruited to the focus groups after consenting to answer three questionnaires over the course of their pregnancy and early parenting period and agreeing to be contacted for interview or focus group if requested. 14 women presented on the arranged dates for discussion.

Men were recruited via an invitation from their partners and signed a separate consent form. 3 men presented for discussion on the arranged date.

Midwives were recruited via internal advertisement at the local hospital where the study is set. 7 midwives consented to participate.

3 obstetricians provide antenatal and intrapartum care in this setting. All three consented to participate in interviews.

Data Collection

All interviews and focus groups were conducted using semi structured questioning. Conversation was recorded using both audio tape and direct transcription. Transcripts were checked for accuracy by a nominated participant in each group.

Analysis

The transcriptions were uploaded into QSR NVIVO 7. Content analysis using key word frequencies and relationships was undertaken by the three authors independently then collaboratively until themes were agreed.

Inducements

Shopping Vouchers were offered to participants by way of reimbursement for travel costs given the lack of public transport opportunities and the distance rural people must travel.

Ethics

This study was approved as part by the Northeast Health Wangaratta HREC and the University of Melbourne HREC.

what's changed in birthing?

History

From an historical perspective much has changed. Child birth in most cultures traditionally occurred at home attended by close female relatives, sometimes with the assistance of a 'wise woman' or midwife. It was not uncommon for women and babies to die.

From the mid-30 s, when the maternal mortality had remained much the same for a century, obstetricians were focused on reducing the unacceptable loss of young women's lives[2]. The rise in caesarean section from 1% in 1946 to 2.7% in 1958 and 4.5% in 1970 was an appropriate response to the recognition that with antibiotics, new anaesthetic agents and blood transfusion available, women were less at risk from surgery, so caesareans were performed more readily.

Over the course of the last century, Australia made significant progress in improving the safety of pregnancy and childbirth. In 1936, there were 600 maternal deaths per 100,000 live births. By 1950, this had dropped to 109 per 100,000 live births[3]. By 1980, maternal mortality had fallen to about 10 in 100,000 maternities[3]. In the last 20 years these numbers have seen little change. For the period 2003-2006 the Maternal Mortality ratio in Australia was 8.4 per 100,000 births[4].

With the enhancement in maternal survival rates obstetricians became increasingly focused on the baby. The improvements in neonatal intensive care in the 1960s and 1970s changed the perception of the balance between maternal and fetal survival. Looking at the number of neonatal deaths in Australia since 1970 there was a reduction from 3,364 a year to 864 [5].

It has been suggested that these improvements in neonatal survival rates have not been due to the commensurate rise in caesarean sections but rather as a result of technological improvements in the care of premature infants and babies born with congenital heart problems and the impact of prenatal screening for birth defects which results in the termination of pregnancies which would otherwise have delivered a child with significant health problems [6,7].

Rates of CS have increased

All clinicians who were interviewed or took place in the focus groups were conscious that the Caesarean section rate nationally and locally has increased over recent times. Clinicians were quick to relate the current CS rate and compare it to previous times in their professional experience. The rise in the rate of caesarean section was viewed as a significant change in birthing practice.

> "When I was starting, the Caesar rate at the hospital in x. was about 18-19 per cent and now in the same hospital, it is now similar to here at 30 per cent" (Obstetrician 2)
>
> "It is a big concern that rates of caesarean section are rising. I feel as group of midwives we are sometimes powerless to change that rising caeser rate." Midwife
>
> "It is a concern that it (CS) goes up and one should rethink policies and recommendations and see what we could do to have less". (Obstetrician 2)

While the rising rate was well acknowledged not everyone saw this as necessarily a bad thing.

"To me, it's not a concern that the caesarean section rate is going up. There is a lot of concern that the CS rate is too high. No one can say what too high is and no one has really addressed what that means. We know there are risks with caesarean section that are not there with vaginal delivery. If everyone had a caesarean section those risks would have to be addressed. You address it by keeping the c rate down. In fact the risks are higher delivering people who are overweight which is coming up to 50% of our patients. The risks are higher delivering 35 year olds rather than 16 year olds. If those factors were addressed, the caesarean section rate would be lower." (Obstetrician 1)

Attitudes: Society, Women, Men, Doctors, Midwives

There was a sense from the clinicians that people approach having a baby quite differently to how they did in previous generations. The clinicians saw babies as firmly attached to a broader lifestyle aspiration. Hopes have been replaced by expectation. Tolerance for poor outcomes is low as we collectively strive for perfection. In addition there was a sense that it was not just about bad outcomes (which no-one wants) – there was a sense that people have desires which cannot be guaranteed with reality.

"The expectations of the length of labour have changed on and off over time. Expectations of outcome have changed, people expect they will have perfect child and the perfect delivery. It's something that in the past was hoped for but not expected. With that has come a change of attitude that if you didn't get a perfect baby that would be someone's fault. But that's not how nature does things " (Obstetrician 3)

"The next big thing was people having smaller families compared to then, so our attitude to families and children has altered. We all expect all of our kids to be highly intelligent, tertiary educated, Nobel prize winning. Looking way, way back, people had four or five kids and it wasn't all that uncommon for one of them to have some minor cerebral palsy and people just accepted that's just the way it is. My mother's first labour was three or four days and she had a baby who died of asphyxia within a few hours of being born." (Obstetrician 3)

Clinicians described a general transformation in societal norms such as the age at which women are having their first babies, the anticipated length of labour, and the desire for comfort, certainty and safety.

"Patients have changed. You were considered old having your first baby at 25, because that was the 90th percentile. Very few had their first baby after 25. Now that's considered 45 or thereabouts." (Obstetrician 1)

"More recently again, we are less prepared and women are less prepared to accept prolonged labours. It wasn't all that uncommon for women in the 80s and 90s to labour for 24 hours. Now if you come in and you've been labouring for 16 hours and you're only 5 or 6 cm dilated you're likely to have a caesarean section not have an epidural and labour for another 6 or 7 hours. That's just the culture. People are not prepared to – society's attitude to what's normal and what's not has changed. People don't expect to labour for 16-24 hours for the first baby. It's all meant to be pretty easy. It's consumerism. I suspect it has something to do with the society we live in. If you're a peasant in India, you accept, to quote Malcolm Fraser that life wasn't meant to be easy. A prolonged labour is just an extension of this painful experience called life." (Obstetrician 3)

> "This is about how we develop. You can see in all sorts of things, how we educate our children - that they are safe, we carry them around in cars. I believe this leads to thinking one can't cope with struggle in life and uncertainties. It's about family life as well. " (Obstetrician 2)

Incumbent in this attitude is a feeling that when a clinician cannot guarantee an outcome they must then undertake a sometimes challenging process of negotiation.

> "It's dealing with difficult personalities, the increased expectations of what you can do, and people's understanding of what you're doing. They're becoming less realistic. They've lost track of what obstetric management is all about, which is trying to stop the disastrous things that happened 100 years ago" (Obs3)

> "There are a lot of family dynamics involved. There can be control freak husbands. People can have unreasonable beliefs and you can sometimes have different scenarios where the patient herself sees it's reasonable what you're suggesting and you can have a very rare situation where the husband doesn't want it, but in the end it's the wife's choice. It's not always easy with control freak husbands" (Obstetrician 1)

One doctor believed these community attitudinal shifts are also reflected in many of the less experienced midwives whose age and socialisation is similar to that of the birthing population.

> "As well, not only the society changed and the demand on O&G but the midwives are changing in their ethical views. From X to here, midwives are thinking they have to have a more technical birth. I feel the younger generation of midwives are more prone to it. We have a different perspective for epidural, but they are less reluctant to go into discussion like, 'Do we need to do that, to have a nice natural birth? 'They get institutionalised. A lot of midwives are losing this aspect that they can bring into a birth. It is possibly a generation thing or what I see in Wang they are less, one of my colleagues calls them, less likely to have [scented] candles. Instead we are having birthing suites with the TV instead of music. The interest of midwives is going this way, either totally alternative and doing home births with no interaction with institutions. I think you could have a bit of that in an institution. Midwives who work successfully in institutions are happy to go along with interventions." (Obstetrician 2)

Once it became accepted that there had been a dramatic improvement in safety, the informants discussed how women and health care professionals in developed nations such as Australia began a drive for a better experience of birth.

> "You also have to allow people's rights. You can't change it by changing the system a lot. It would help if you could change people's attitude and expectations. That's where doctors have themselves gone wrong thinking they would have full control over things and would tell people that. When I was a medical student, the doctor was God." (Obstetrician 1)

> "Birthing practises have most definitely changed over 30 years. It has changed from being completely doctor oriented to completely patient oriented in many respects. That's not necessarily a bad thing. When I started as a student they did deliveries in stirrups with two to three patients to a room. Patients were told what to do by the midwife who said push, and told them to shut up if they were screaming. They were stitched up and shuffled back to the ward. Now we're treating people more humanely. That attitude has changed – often to the extreme. Stirrups is still a good way to deliver some people and sometimes you have great troubled convincing people of the 50 positions they've tried, they will get there if they put their legs into stirrups and it works."(Obs 3)

> "Birthing practices have changed. They changed one way then started going back the other way. When I was doing my training in early '80s we were moving away from a completely medical model of obstetric care into a more - while we were aware of issues, we were not as regimented. A lot of things changed. It's hard for people to remember. All that silly stuff about shaves and enemas and all that rubbish. There used to be absolutely strict protocols that had to be adhered to for women in labour. " (Obs 2)

Societies' broader relaxation of social protocol and etiquette have had an effect on the birthing room atmosphere and birthing population.

> "When I was first a student even having partners in the room was new and birthing in different positions was weird. Birthing sitting upright without having your legs up in stirrups was strange or using water to assist birth. A lot has changed. Babies still come out the same way though." (Midwife)

> "All that silly stuff about shaves and enemas and all that rubbish. There used to be absolutely strict protocols that had to be adhered to for women in labour. And strict rules if someone was not fully dilated for an hour you had to deliver them by forceps. We got a lot more relaxed about that silly stuff." (Obstetrician 3)

The clinicians reflected on a sense that the 'rules' were ambiguous. While there had been something of a relaxation in the clinical behaviour of the labour ward, the cycle had turned from the strict protocols of the past to a friendlier feel, to now a renewed dependence on technologies and their accompanying imperatives.

> "In the '70s and '80s everyone wanted a natural birth, and then there was a time that everyone is booked in early so we don't have births on the weekend, so there are waves." (Obstetrician 2)

> "Birthing practices have changed. They changed one way then started going back the other way. When I was doing my training in early '80s we were moving away from a completely medical model of obstetric care into a more - while we were aware of issues, we were not as regimented. A lot of things changed ... I don't have any strict rule in my head – it depends on if a pregnancy is progressing or not. If a woman had had a previous straightforward normal delivery and this time she was pushing for two hours I'd be concerned, but if it is a first birth and the mother is not exhausted and the baby is ok, we wouldn't necessarily do anything. These are minor examples to show we were moving away from the strict medical model and it was becoming a bit of a warmer experience. Now I detect in my registrars in training who come through here a return to strict protocols. " (Obstetrician 3)

New technologies

From the clinicians perspective attitudes *and* technology has changed the way they interact with women. Clinicians see themselves more as masters of, and sometimes slaves to, technology certainly not as masters of women or the birthing process.

> "A lot is for the better but more emphasis is on technical side. As technology gets better, we tend to use it more. Ten years ago we didn't have a registrar, and they bring new practice. There are more doctors around. "(Midwife)

> New technologies have a very valuable place if used properly for women who need them, but there are women who can birth with no problems whatsoever and those technologies don't apply to them.

They do get these technologies anyway. There is a tendency to use them more than is needed. This is coming from doctors not midwives. (Midwife)

Like an admission CTG [Cardio tocograph - foetal monitoring device) - from my understanding there is no evidence to suggest that needs to be done on everybody but we do it because other centres do it. If you don't do it, if you make that clinical decision not to do it and there's no policy to do it, the registrar will say, 'Where is the admission CTG? And why hasn't it been done?' And he's cross. (Midwife)

"It was less invasive doing things – they had very long labours, women were rarely induced if at all. It is turning into a more proactive approach now. "(Obstetrician 2)

Obstetric Practices

The three obstetric practices that have tipped the balance in favour of doing more caesareans from the clinicians' perspective are that, relative to the risks of surgery through CS, high forceps deliveries and vaginal breech deliveries are no longer acceptable. The third practice is the use of electronic foetal monitoring which some believe has become indiscriminate.

"Caesars are used now for situations where once there might have been high forceps or mid cavity forceps and now will be a caesarean"(FG M)

"The next thing is foetal monitoring, which is 30-40 years old, where we can see baby's heart during labour. We are going to act on it if it looks abnormal and that means doing a caesarean section."(Obstetrician 3)

"As a student and new graduate, breech birth was normal. Women birthed breech babies but that doesn't happen now unless they come in fully dilated and we can't get them to theatre in time. New registrars are not learning breech birth so in 10 years there may not be many who can do it. They learn it in theory the same way we do, but it doesn't happen in practice now." (Midwife)

Does evidence support birthing choices?

Pregnancy and birth cannot be easily reduced to the conditions of a clinical trial. In the medical model under which the Australian health system is managed, change in practice usually follows evidence from information disseminated through peer reviewed journals, or professional college clinical practice guidelines. In a world where statistics are available at the press of a Google button clinicians and consumers alike seek facts and proof to guide decision-making, however much of the evidence in obstetrics remains interpretative.

"In O&G, we looked for evidence to do more trials to see if we can prevent more, and show more evidence, which is hard in obstetrics, to find evidence for treatments." OBS

"Of course, you are led by wanting to do the right thing which means, is there enough evidence? One is always wanting to have back up knowledge that what you do is right" (Obs 1)

> "What concerns me is that we encounter more families or women wanting a caesarean section without thinking about a vaginal birth, which is a very natural process and unique experience for a growing family. I feel they don't know about the evidence, what it does to the baby and the mother." Midwife

> "I try to get the registrars to produce the evidence that we have to be doing these things. Sometimes they can and sometimes they can't. They keep us on our toes and teach us new stuff and we teach them old stuff. I don't necessarily see much evidence for things they are doing."(Obstetrician 3)

> "The midwife does have significant impact on how women labour. It's been shown in research papers as well as my anecdotal evidence. One of the issues with bigger hospitals than ours is they just don't have the staffing for one-on-one labouring" (Obs 2)

> "I always ask for research and stats. I want to back it up and know the facts. That's why I am participating – I want to contribute. I want to know who's caring for me is up to date so I can be confident in them as well." (FGPW)

There is, however, one absolute - the overall improvement in surgery and anaesthesia. In a medical model of birthing such as it is in this setting, this reassures clinicians and consumers alike. It is not surprising that a decision to undertake CS is undertaken more lightly than it would have been in the past when there was a real risk of death or serious morbidity from the surgery.

> "If you take the long term look, and go back 40 or 50 years, in fact the one thing that's altered caesarean section rates is that anaesthesia has got a lot safer. Fifty years ago it was moderately unsafe because you needed a general anaesthetic and it would be a bit dangerous "(Obstetrician 3)

The one piece of evidence that seems clear to consumers and clinicians is that catastrophic harm from doing a caesarean is rare. Delayed recovery times, infection, bleeding, and problems in subsequent pregnancies seem subtle by comparison with the possibility no matter how remote of a difficult labour and death or harm to the baby.

> "There is huge information from the media that caesarean birth is safe. If you have it, you know when, the time, there's no labour, no risk of the baby dying in labour." (Midwife)

It's a risky life

A pervasive sense of risk was palpable in pregnant women's and clinicians' discussion of childbirth.

> A birth event can easily turn into a risky event ... It's very close that a woman can bleed to death or something severe can happen. (Ob 2)

> Birth is risky. If you read historical biographies, I remember reading one about mathematicians, it was obvious one of the reasons women didn't get a long way in mathematics is because they kept dying having babies. Mathematicians had two or three wives not because they wanted a change, but because their wives died. Plenty of babies died. Look at cemeteries babies who were buried with mothers 'aged one hour'. It is inherently dangerous. We can overcome blood loss and control

infection most of the time. We can give pain relief and treat the stuffed up physiology so it's made it a whole lot safer but it's still not guaranteed safe - people still die. (Ob 1)

99 per cent of the time it's not [risky], but one per cent of the time it can be. It's not a conscious thought that goes through my mind but I guess it is risky because if you look at Africa and East Timor, maternal mortality is approaching one mother dying per 50 to 100 births in some places, so I guess it is inherently risky for mothers let alone babies (Ob 3)

Regardless of delivery method, risks in childbirth include bleeding to death, embolisms, clots, placenta praevia, wound infections, pre-term deliveries, breech births, incontinence, and more. Aggravating factors can be older aged mothers or obese mothers, diabetes, big babies, birth after caesarean section or multiple caesarean sections. Simply being in hospital has an attendant risk of infection or drug error.

The whole being in hospital is risky. Look at the stats, there were 10,000 drug errors in Vic in a year, alone. These are the risks you live with in health. (Midwife)

"The babies are bigger. You have mixed races – little Asian women and big Australian farmers. "(Midwife)

For couples who have achieved a pregnancy after many years or through assisted reproductive technology, any possible hazard must be contained.

You have IVF, women who've become pregnant on their 12th cycle of IVF, the precious baby, zero risk, they will take no risk. "(Midwife)

Risks of vaginal birth

'People have been doing it forever. If apes and cave women can do it, then it seems that's the way the human body is best able to deal with the trauma of childbirth. If that's medically feasible, it's got your best odds for working out for the child and mother to be as healthy as they can be. In a hospital you have risks straight away and risk to the child and mothers' bodies. There are risks inherent in the process and other risks, and at a guess, the odds are better going the natural time honoured method. "

(FGMen)

In a vaginal birth, [risks are] the baby getting stuck, lack of oxygen, getting distressed. (FGPW)

From the baby's point of view, vaginal birth is riskier than caesarean section. The thing that's most traumatic is getting the head through the bony pelvis ... If you're just looking at the chance of the baby being damaged or hassled, they don't come out through a hard bony pelvis when they come out through a caesar, so the risk of physical trauma to the baby is lower. (Ob 3)

I think most women understand that caesarean section is safer to the baby and that's where the pressure comes from. People's attitude to surgery in general is varied, because people see surgery as normal. A lot don't see a problem in having surgery to fix something that's minor. A lot think that

about a Caesar, 'I'll just go and have a caesar'. They understand it's safer for the baby and it most certainly is. People have different problems and different risks so vaginal birth may be a hell of a lot riskier for baby and the mother. (Ob 3)

They put emphasis on those risks, but they don't look at the risks of the treatments. The risk of leaving a woman to her own devices is the one that gets the most attention. (Midwife)

Risks of caesarean section

In non-risk situations, vaginal birth is always less risky. Surgery comes with a lot of risk and there's the recovery time. A woman with a caesarean is in recovery for x time and you don't get the mother-baby bonding from the moment it's born. (Midwife)

The baby's lungs with a caesarean. When they come through the passage, it squeezes the liquid out of the lungs. That doesn't happen with a caesarean pregnant woman (midwife)

Even though we can do [a caesarean section] in 25 minutes, it brings up the risk of a clot in the leg vein that can turn into an embolism. The risk is still high two weeks after. The risk is there in vaginal birth but not as much. After caesarean section, with the next delivery there are risks, whether to go for vaginal birth when there is a scar. (Ob 2)

The major mortality risk is CVT, blood clot. A clot in the leg doesn't cause you to die but if it moves into your lungs – 2,000 people a year in Australia either have serious consequences or die because of clots related to hospital stays. (Midwife)

From the mother's point of view, there is an extra risk of surgery on top of the normal risk of haemorrhage and infection. The damage to uterus is, by definition, controlled. Over the years the risks of surgery has reduced – but it's still there. (Ob 1)

Things can get left behind in a caesarean. They count all the instruments. It's off-putting. They get to 9 and you think, where's 10? (Pregnant woman)

These days if you look at the figures for elective caesarean sections versus normal vaginal births, the risk for the mother is only very slightly increased for caesarean section, and the risk for babies is slightly increased in terms of respiratory problems. (Ob 3)

Risks of complicated labours

A lot of risk for the mother is related to the situation the mother was already in, like pre-eclampsia. (Ob 3)

Caesars are sometimes done in very difficult situations ... For a mother with a complicated labour; caesarean section is safer than complicated labour. People die from obstructed labour and that can be managed by caesarean section. (Ob 1)

The pregnant women who informed this research held a range of viewpoints.

Both are risky.

> Caesarean is riskier.
>
> Either depending on the situation

Yet,

> Everything's a risk; a drive to Melbourne will be riskier. (Ob 1)
>
> ... in our society I don't go around thinking consciously, 'this is a really risky business' ... All of the risks are rare. (Ob 3)
>
> ... life is risky. You have to put it in perspective. There are no guarantees. (Midwife)
>
> Everything's risky. (Pregnant woman)

How are people feeling about the birth process?

> No one can tell you exactly what's going to happen to you. It's a very personal experience. They can't say how it will be for you. (Pregnant woman)

The midwives agreed that this seminal experience of childbirth is a very personal one for each woman.

> Our perspective looking from the outside, we don't always know what a woman has taken from the experience. Something that looks normal and fine from the outside can feel different from the woman's perspective. Some women can feel fine with a very intervened-with birth. (Midwife)
>
> Some have very high expectations of themselves and feel they've failed if they want to do everything naturally and if their bodies don't do that and they need induction or a caesarean. They feel their body has let them down. (Midwife)

The midwives spoke of the importance of the birth journey for women's sense of themselves.

> Women can grow in self esteem and confidence through pregnancy and birth and for some women it might be the first thing they've done right in their life. (Midwife)
>
> It's really big to see their confidence grow. Motherhood is just starting with pregnancy. It's a big journey. (Midwife)

The ideal for women and their partners is to have a natural birth. Some women spoke of this as a life-long expectation.

> All through my whole life I wanted a natural birth. (Mothers with babies focus group)
>
> I want to experience that natural thing and what your friends have told you about their natural births. (Pregnant woman)
>
> I want natural birth. Ever since I can remember, my mother said how she only had gas. (Pregnant woman)

> It's always been, 'You were here within an hour and so was your brother and sister'. (Pregnant woman)

One compared her own unsatisfactory experience with childhood stories from her mother about the joy of birth.

> Mum had natural births and fed really well, and if I talk to her [about childbirth problems] she doesn't know what to say. I'd love to do it in a way that is as beautiful and natural as she did. It's not a direct influence but I'd love to have that experience that [my parents] had. I just feel it myself. It's a want. (Pregnant woman)

Like the concept of 'motherhood' itself, achieving a beautiful, natural birth has cultural meaning as something to be revered and a milestone in a life well lived. For some women, the circumstances in which they give birth relegate their birthing experience to more of a nightmare than a dream.

> I had a beautiful pregnancy. And I thought we'd have a beautiful birth, but we found out we had to have a caesarean. (Pregnant woman)

> I was told I'd have to have a caesarean section and I was absolutely beside myself. It was the worst thing that could have happened. (Pregnant woman)

> My baby was breech 6 weeks before so I was told it has to be a caesarean. I bawled and bawled and felt cheated. (Mothers with babies focus group)

> I went from a natural birth in six hours in my first to the second where I was given caesarean. I should have had the option for natural birth. I felt like such a failure. I bawled for five weeks. (Mothers with babies focus group)

> My little girl was breech so I had to have a caesarean. I didn't like being separated from my partner having the spinal block. And then I missed out on a hour after the child was born because you go to recovery and you are in a blur. I didn't enjoy it. I don't know why people would ever choose caesarean section. (Pregnant woman)

> [With a caesarean section] There's long term pain and other complications. I had an infection and lost my milk. It's emotional, all of a sudden the baby's out and you didn't really do anything (Mothers with babies focus group)

For some, practicalities were the main consideration – being able to get back to normal duties of caring for other children and the household, driving and resuming 'normal' life.

> I've had two caesareans but having a natural birth and being able to do more things, and driving, would be good. (Pregnant woman)

Most women and their partners seemed to take the philosophical perspective that the outcome of a healthy mother and baby was paramount.

> It's just a natural process, I wouldn't think about it any other way. If it had to come to caesarean, then OK but it's not what I'd prefer. (Pregnant woman)

> I think that's why they were trying to let me down so early. After 32 hours, they said, sorry you've tried really hard, it's taking too long. I was like, 'Just get it out'. (Mothers with babies focus group)

One woman spoke of being pressured by the range of differing advice given to her by clinicians. As a result, she was confused and frightened.

> There's a lot of strong opinions around. You pick and choose what you want to take in. When I first went to the midwife, she was very much that it could be either way – caesarean section or vaginal. The registrar was very pro-caesarean section. That put me under pressure. Then I saw the midwife and burst into tears. She's into natural birth at the end of the day because she's a midwife, but she said, 'If there's any risk, we're not going to let anything happen to you or the baby'. You have things on the internet that are scare tactics. After the registrar's talk, I was scared but when I spoke to [the obstetrician] he said the risks are the same for natural and caesarean. (Pregnant woman)

Fear

Fear surrounding childbirth is not new. Historically letters and diaries have revealed a fear of pregnancy and labour that was based on a real possibility that the woman may not survive. Many women had a friend, a mother, or a sister who had died in childbirth or had known the sorrow of a stillbirth or the death of a newborn. The dangers and suffering that women endured in childbirth affected other family members as well. One husband in the1800s wrote:

"[childbirth] is an hour of harrowing anxiety. . . . There is surely no pain like it in the world. . . . It is the rending asunder of all but soul & body . . . What a load from the heart of a husband . . . [when] the precious life of a wife is spared."

Robert F. Lucid, ed., *The Journal of Richard Henry Dana, Jr.* (Cambridge, Mass., 1968), 1:68–69.

Despite the actual risk of catastrophe being very small fear seems a natural part of birth today also – for the woman and her family, the midwives and the obstetricians.

> It's a new situation in life. It's a normal sense of fear. (Obstetrician 2)

> I don't know if it's right or wrong, but a very learned woman who I admire said to me as a junior midwife that if your heart didn't skip a beat every time, you probably aren't on your game. And mine does. (Midwife)

The women

Although rare, women may feel so afraid of labour that they will elect to have a caesarean section for this reason alone.

> I think there is a trend to go straight into an elective caesarean section without thinking of having a vaginal birth. [People are] not getting on to working with the anxiety and fear about a normal birth. There is a lot of educational work to do from our part and midwives' part, to work with women with their fears. Fear about coping with pain - would they cope with the situations that could happen, fear of the unknown. (Obstetrician 2)

> There's all this stuff about vaginal birth causing prolapses and urinary incontinence but I don't think that's at the forefront. I think it's more to do with fear of labour ... Sometimes I think they're

> influenced by friends, family, sisters who've had long labours and finished up with a caesarean section. (Obstetrician 3)

> No one just asks for caesarean section for no reason. The reason might be trivial (to me). There is something making them ask that. If you can address that concern in most people in any other way than doing a caesarean section, then you do. But some people, even though you look at physical risks factors, some are asking because they have a real concern. That needs to be addressed. It may be a wrong idea engendered in them. It might be a real one, they might be scared stiff. (Obs 1)

More commonly, women have an anxiety that things go well.

> The fear is generally that the patient is fearful that you're not going to be able to stop the disaster. (Obstetrician 1)

Obstetricians feel a palpable sense of fear from women, their partners, and sometimes from midwives when entering a birthing suite.

> I would think the woman is fearful and everyone involved could have some fear especially when the doctor is called in. (Obstetrician 2)

They are only called to attend when the labour is not progressing well, so a sense of fear is natural and logical.

If women and their partners have experienced a previous birth where the baby died, they are fearful of it happening again. Women may be in an exhausted state, or in so much pain that they, and their partners, are fearful.

> If the medical team is called in, it's usually because there's a problem. If I'm called in, decisions have to be made and the patient is usually well aware there's a problem ... The fear is usually from the patient or husband. There are all sorts of people in there. Sometimes it's others. You can get a sense of fear, a feeling that someone is scared stiff. If the patient is not in a lot of pain then, it can be her. When the woman is exhausted, the fear is from husband or support person. (Obstetrician 1)

> Frequently, women in labour are fearful, particularly if they're having a long labour and not getting adequate pain relief. Frequently their partners and I think being a partner in labour is a very difficult thing. (Obstetrician 3)

Obstetricians and midwives

One obstetrician was fearful about communicating well and being able to resolve the challenging situation well.

> I have to deal with my own fears when I'm called in to the birthing suite to help or solve something. But the fear is all sorts of thinking in how to deal with it. Fear in a way, what will it be, then fear about will you connect and could you get the message over. It is fear of the unknown. (Obstetrician 2)

Both obstetricians and midwives reported feeling fearful in emergency situations. One spoke of the contagious nature of fear and the need to manage their own fears.

> Some of the doctors are just fearful of birth and don't trust that it can and mostly does just happen. There are certainly risks, it is a risky passage but it's not that frightful. Especially if anything starts to deviate, some just panic and panic is so not useful. It panics everyone else. It's contagious. (Midwife)

> For me, the others doctors, midwives get a bit fearful in the delivery suite when things are not going well, when you've got terrible foetal heart monitoring and you know it's going to be 30 mins before you can get to a caesarean section, or when someone's had a massive bleed after delivery. It can be pretty stressful really. (Obstetrician 3)

> Sometimes my instinct picks up fear from parents or from medical people ... Sometimes I go out of the room and do a lap to calm my fear down because sometimes it is me. (Midwife)

For some midwives, it can be reassuring to pass the responsibility over to an obstetrician.

> Some midwives would like a registrar to take over. You can hand responsibility of everything to a doctor. That's a fear factor. You've got this doctor as a backstop. (Midwife)

Fear of litigation

Fear of litigation has been a major concern to obstetricians for some decades and led to these local obstetricians giving up private practice because of the risks involved and the exorbitant insurance premiums. While in recent years the Federal government has given doctors assistance with insurance costs the spectre of a law suit remains frightening.

One obstetrician noted that doctors are liable for being sued for something that is out of their control. In the Australian context parents may need to sue a doctor in order to provide support for a disabled child. This is not the case in countries such as New Zealand where a no fault accident insurance scheme was introduced in 1974 after a major report concluded that a tort or fault-based liability system was too erratic for those who needed a secure source of support.

> Litigation affects how you do things. It's a big issue for me. It's the reason we don't do private obstetrics ... Everyone has cover, so it's not the money but it's the trauma of going through the court system and being held up to ridicule for something you thought you'd done right. Otherwise, where someone's done something horribly wrong, they're settled out of court. If they've done the right things, and it still has a bad outcome, it's not belligerence on the part of the parents. Rather, they have baby who needs care and attention and need money to bring them up. It's not that they hate the doctor. (Obstetrician 1)

The threat of litigation may extend even beyond an obstetrician's professional life, as doctors are liable to be sued for up to 25 years after the incident happened.

> One of the biggest hassles is that someone can still sue you 25 years later. You have people who retire at 65 who are sued at 80. It's not common but it does happen. A fellow [I know] who retired 15-20 years ago was sued a couple of years ago for a breech delivery in the days when all were breeches were delivered vaginally ... The government has limited the time for suing but the courts can vary that in retrospect ... it used to be 7 years, but it started when the person became an adult, so when child you delivered became an adult he could sue you from 7 years after becoming an adult. You keep your notes for the minimum required time and theoretically you can burn them, but theoretically, a person could say, I didn't know I had a problem till now, and you've burnt your notes. (Obstetrician 1)

Some obstetricians take the philosophical approach that our society is increasingly litigious across the board.

> I guess societal attitudes have changed and they're not going to change back. Whether you're running a bar or a bus company or being a doctor, you're far more likely to be sued than 20 or 30 years ago and I don't think that's going to change. (Obstetrician 3) (this was earlier??)

Yet the personal threat seems to hover and to influence practice.

> The old medical legality comes in where if someone's says, 'I desperately want a caesarean section', and I say no, and then they come in and attempt vaginal delivery and something goes wrong, I'm not in a good position at all ... In that situation where, for no particular reason, [women] are requesting a caesarean section, in the past we would have tried really, really hard to talk them out of them. These days I'd be inclined to just present the information and say, 'There's no good reason for you to have a caesarean section', and outline the risks. But if they say, 'This is what we want', we're not going to talk them out of it any more. (Obstetrician 3)

For midwives, too, there is a heightened awareness of litigation risk, and the chance they will be called on as witnesses.

> It makes you document properly - times, obstetricians, when you called people if you were concerned. Litigation has escalated over the years and we've been taught as a result to dot i's and cross t's. My friend went to coroner's court and they actually praised her on her times and documentation of when she notified people. We try and do that. Particularly if you think something is dodgy. (Midwife)

> And then you're overdoing it sometimes. It's never good to be led by anxiety and fear. It's happening more as the access to be able to sue is easier, I would think, but I don't like to have that on my mind. (Midwife)

When parents would take legal action

There appeared to be consensus amongst the women and men who informed this research that legal action would be a last resort. Informants stated that it would be a difficult thing to do, especially during a traumatic time, and that there would have to be clear evidence of negligence or fault.

> You can imagine that it would take a huge toll. (Pregnant woman)

> And you'd be grieving as well. (Pregnant woman)

> It would come down to whether you feel they haven't done their job and were breaching their duty of care. I don't know if I would sue. It's a hard process to go through. You have to put a lot aside to really focus. (Pregnant woman)

> I'd have to see blatant negligence, which seems a very unlikely scenario to play out. I work for a law firm and could get it cheap but wouldn't do it. (Father 1)

> I would seek legal advice if I felt it necessary. I have a problem with that because it's very American. I don't think we're that way. It would be negligent on your behalf to not seek (a) reasons why things

have happened incorrectly, (b) who, if anyone is at fault and, (c) what recourse you actually have. I wouldn't say my baby's dead, I'm going to sue you. (Father 2)

The only legitimate reasons suggested for taking legal action were altruistic. The women and men would want to prevent it happening to someone else and would want the system that caused the problem to change.

> From my point of view, if there was horrible incompetence, and I felt the hospital was trying to hide it, I might try to make sure it wasn't going to happen to the next person. (Pregnant woman)

> In extreme situations, though, you'd have to think about it. If someone had done something that bad, they'd have to be held to account. I'd like to see them criminally sued rather than for me to get financial recompense. That person shouldn't go on to do the same thing to another person. (Father 1)

The women and men agreed that they may take legal action if their child was born with severe disabilities as a result of negligence. If litigation was the only way to provide the best lifetime care for a severely disabled child, they would consider it. Yet, even in these circumstances, there was a sense that people are reasonable and would not take someone to court on a whim.

> If you could see clearly that someone had fucked it up, someone might have to take responsibility. It would depend, if you'd been given options and you'd chosen one that then led to disability and ongoing pain, I'd have to take that responsibility and say, I made a choice and it turned out to be a wrong one [but] if the obstetrician comes in at the last minute because he was playing golf and you could smell the beers on him, I'd sue the pants off him. If your child is born less than perfect, it's a road to hoe, but that's life and it wouldn't help me and my family deal with it by spending time pointing fingers. I'd like to think that health professionals involved were doing their best and if things went wrong, then they just went wrong. (Father 1)

> I'd sue for the cost of medical expenses for the child if it was their fault. During birth, their shoulder can get knocked out and it can't grow properly – if it was something like that. (Pregnant woman)

> If the baby has disabilities, it might change the dynamic. I wouldn't seek recompense as a means of making them suffer but if the baby has needs and on going medical care, you want to give them the best care. (Father 3)

Who decides – caesarean section or vaginal birth?

The three obstetricians who informed this research stated that, in planning for the birth, women would ultimately make the decision as to whether to opt for a vaginal birth or a caesarean section. They stated their role was to fully inform the woman about her choices given her particular pregnancy, and to try to understand her concerns. If there was no indication that a caesarean section was required but a woman requested one, the obstetricians' position was that it was her choice, and that it could be counterproductive to argue against it.

> If you just put your foot down and say no, apart from being patriarchal, you know that when they do come in for labour they won't have their heart in it, and will probably end up having a caesarean section because of failure to progress. You have to be committed to labouring. (Obstetrician 3)

> When I see her I try to work out what was the reason behind it. I would hope it would always be the women's decision. If she still wants a caesarean section, she can have that. (Obstetrician 2)

> Giving them a real view of outcomes and different scenarios is helpful but not all their concerns are rational and if you haven't addressed their concern you still have a problem ... I don't think I've ever had a patient asking for [a caesarean section] on a whim. They've got concerns ... Occasionally, I've been pressured not to do caesarean section ... [if] the patient really wants a vaginal birth ... you go through the risk factors and you accept that they have a choice in the matter even though you would have preferred a caesarean section. (Obstetrician 1)

> In that situation where, for no particular reason, they are requesting a caesarean section, in the past we would have tried really, really hard to talk them out of them. These days I'd be inclined to just present the information and say, 'There's no good reason for you to have a caesarean section', and outline the risks. But if they say this is what we want, we're not going to talk them out of it any more. (Obs 3)

Their own opinions about caesarean section seemed to sit in the background

> Caesarean section is easier for us as obstetricians, we don't have to discuss all the time, it's much easier to book her in, instead of carrying her, caring for her and her concerns. (Obstetrician 2)

Some of the women who had experienced a Caesarean expressed a degree of ambivalence about the decision.

> I probably could have a choice but I wouldn't risk it.(FGMWB)

> A 40 minute caesarean operation sounds great. I thought there's no way I'm going to push the baby out. I'm 44 so they probably wouldn't let me anyway. Maybe that's because they don't want to be sued if something went wrong. It was so easy, the healing was easy.(FGMWB)

While others felt more information would have prompted them to be more involved in the decision making.

> If I was told I could have been induced 2 weeks earlier, I would have tried for a vaginal birth because she was smaller than he was. I had a fear of having another big baby and complications. I didn't know I could have done that. I just assumed, I would have to have a caesarean. (FGMWB)

However, in the birthing room, if there were difficulties or labour was not progressing well, the obstetricians felt the final decision about whether to perform a caesarean section was theirs. They were clear that when they are called to the birthing room it is because something is not going right and their role is to act decisively.

Midwives spoke about pressure from registrars wanting births to proceed in a text-book manner and one of the obstetricians noted this tendency for new registrars to return to the birthing practices of the '50s where there were rules and measurements to go by which dictated how to manage a birth.

> Now I detect in my registrars in training who come through here a return to strict protocols. Probably because they come from hospitals that struggle to cope with 2000 deliveries ... If you had a previous caesarean section then you must have A, B and C ... they seem to have really fixed notions again about what has to be done ... They seem to be adhering to very strict protocols again ...I don't necessarily see much evidence for things they are doing. (Obstetrician 3)

> It's a fear of mine that medical staff will take over and not let things happen naturally. (Midwife)

Midwives described strategies to get around this pressure.

> The other thing some people get knickers in knot about is that, for a woman who doesn't want to push but she's fully dilated, you have to write down 9cm so she has more time. (Midwife)

> It's the time limits at the end. If you're a primi you've got 2 hours at the second stage otherwise we're intervening because 2 hours is the cut off, and for multi the cut off is greater than an hour. (Midwife)

Who influences?

The philosophy of practice varies considerably from hospital registrars to midwives, with obstetricians somewhere in between. There was a sense that the obstetricians trusted the midwives and that this relationship was mutually respectful.

> The consultants trust and respect us, while the registrar asks, 'Well, is she fully? How do you know? Have your done VE?' which shows they lack confidence and have more time on their hands. While the obstetricians get on with their jobs in their rooms and they trust you. They know you're looking after the woman. (Midwife)

The obstetricians noted the strong influence a good midwife can have on a birth outcome.

> The midwife is the most important person other than the woman and partner, the midwife is the most important partner in pregnancy and delivery. I just want to be in the partnership, guiding them. (Obstetrician 2)

> The midwife has a lot of influence on the outcome of the pregnancy. The midwife in our ante natal clinics have a lot of influence on pregnant women but once in the delivery suite if they are looked after by a confident and competent, relaxed midwife the woman and partner pick up those vibes ... The midwife does have significant impact on how women labour. It's been shown in research papers as well as my anecdotal evidence. (Obstetrician 3)

> I've experienced lots of different places, lots of different midwives, lots of different circumstances, but nowadays, in general, keeping patient expectation real with a good midwife, or stuffing up their expectations entirely with a bad midwife ... Most midwives I've worked with do a great job of keeping patient cool, calm and collected, labouring nicely, and with real expectations of what's going on and what's likely down the track and what the outcome is likely to be. As much as it involves crystal ball gazing, mostly they get it right and we don't have to be involved. As well as they're bloody good at nice normal deliveries and keeping people happy. (Obstetrician 1)

Midwives trusted the birth process and one described her role as 'being' with the woman giving birth.

> When I was at uni and had to write our philosophy of practice, after reflection I came to think it was the *being*, being attentive, being with the women. (Midwife)

Obstetricians themselves pointed out that they are only called in when a natural birth was threatened.

Both midwives and obstetricians were critical of the tendency for registrars to rely on measurements and technologies to manage the birth process. This is perhaps an inevitable result of their inexperience, but the hierarchy of the hospital institution is such they registrars can over ride the opinion of the midwife. The same hierarchy exists with midwives and anaesthetists, and one midwife spoke about a common experience of anaesthetists negatively affecting the mood of the birthing room by their attitude.

> When the woman is asking or needing epidural, and the anaesthetist comes in, they can be difficult to work with, and rude and insulting and non-caring for the women. They're just there to do a job. It's the one thing in labour ward that I dislike and fear. I've had experiences where an anaesthetist was not being able to get the epidural in first time and he gets crosser and crosser, I feel for the woman but feel I can't be a true advocate for her because of the atmosphere in the room because of him. I feel a big gagged by him. I always feel disappointed in myself. A lot of midwives have experienced that too. (Midwife)

Yet there is evidence that midwives themselves are moving towards a more interventionist approach.

> As well, not only has society changed and the demand on obstetricians but the midwives [too] are changing in their ethical views. From Germany to here, midwives are thinking they have to have a more technical birth. I feel the younger generation of midwives are more prone to it ... as one of my colleagues [says, they are] less likely to have scented candles ... Midwives who work successfully in institutions are happy to go along with interventions. (Obstetrician 2)

Theoretical preferences of parents – vaginal birth or CS?

On the face of it, expectant and new parents and clinicians all indicate a belief system that supports normal birth. It makes sense to them but never at the expense of compromising the mother or baby.

> "I'd never thought of any other thing (than vaginal birth), never thought of intervention in any other way. It never crossed my mind that R would have to have a caesarean. We've been blessed in that way and it's always come up trumps. We're pretty fortunate." (J, FG Men)

> "We started from the presumption of vaginal birth as the time honoured way, so unless there are reasons against it, I can't see a reason as to why I or we would prefer caesarean section for the birth of our children. We can't see why having a caesarean section would be preferable." (T, FG Men)

> "If it (which one??) was the medical advice that it was the best way to have the best outcome for the mother and child, I wouldn't hesitate." (FG Men M,)

Husbands or partners can be influential in birthing choices, and may see caesarean section as an easier way to survive childbirth. Obstetricians noted the importance of communication in the months leading to the birth as well as during labour.

> From couple to couple it will be different as to how much influence the partner has on each other's decision, but I think it's pretty big. I see quite a few males not involved in the pregnancy, it's easier for them to say, just have a caesarean section and the problem seems to be solved ... Quite often partners are very helpless in their own position and see that she's struggling at the end of the pregnancy ... and then she goes overdue and needs closer follow up because she's overdue, and everyone is impatient. Some partners see her struggling and think it's easiest to do an elective caesarean section. (Ob 2)

> I think being a partner in labour is a very difficult thing. There's not a lot of useful things to do except hang about and worry. In terms of holding hands and back rubbing, it's ok, but I think a lot of men seeing their partner distressed with pain - having been there myself - it's very difficult ... You'd have to say to the partner, 'It's highly unlikely to be as long. If you're having a long labour we'll bail out quickly and have a caesarean section a lot quicker than we did last time' (Ob 3)

> He tries to influence me, and I go, 'Yes, dear'. I decided I wanted a natural birth this time. I explained why and he explained he just wanted a wife all healthy and here's bub all healthy. He doesn't want to do the whole stressing thing. He said, 'It would be easier for me to hide behind a sheet, than to see all the gore if you're giving birth'. I said, 'You don't have to be down that end'. It influences me to a point. He doesn't want to lose his wife and baby, I can see his point but it's what's easier for them. He thinks it's easier if I have a caesarean, but I think, 'I can't have my toddler sitting on my lap, I can't drive, I don't want to rely on other people. I'm not being selfish wanting a natural birth. I don't want my toddler thinking, 'Why isn't mum cuddling me anymore'. He's thinking about himself.(FGPW)

Most of the women spoke of having partners who were supportive of their decisions – perhaps sometimes to the point of apathy.

> My partner is totally positive. I have this vision. I need him to be saying, it's OK, all under control, all good and not being grumpy but being supportive. He's at the stage of saying, 'Whatever you want, it's all about you'.

> C is very supportive but sometimes we'll interpret medical advice differently. I know I'll talk him around in the end. He'll say whatever I want.

> My husband is pretty laid back. I'd like him to have an opinion.

> Mine's pretty laid back as well. He does have an opinion, but it's just whatever happens, happens.

Request for CS

The media notion of women requesting CS for reasons of convenience, cosmetics or career was perceived to be a metropolitan phenomenon. There was awareness from some women however that if they had a CS they may be categorized in this way by the community.

> "A couple of girlfriends were silly enough to be in Melbourne in high powered job. They had such restricted maternity leave. One girl had to be back after 6 weeks or she'd lose her job. They factored in caesarean sections and the dates. So some women do have those pressures on them. They have to weigh up decisions based on work rather than what's best for them." (FGPW)

"If you're in a situation where someone's asking for a caesarean section you go through the potential risks of caesarean section versus vaginal birth, whether they are requesting repeat caesarean section having had a previous caesarean section in a previous labour or whether they are requesting caesarean section for non–medical reasons, as is increasingly common. It happens far more to colleagues with big city private practices. Not infrequently someone who's having normal pregnancy would request a caesarean section. Certainly you'd go through the risks versus benefits with each one. Often it's falling on deaf ears once people have made their mind up" (Obstetrician 3)

"There's a community thing where if you've had a caesarean section, you're looked down on. My husband was down the street with the baby who was only a week old, and some acquaintance said, 'We heard you had a caesarean'. He had to say it was an emergency caesarean. He felt he had to justify it. We had to justify having a caesarean. It's more from strangers than those we know. The stats are so high for caesarean section, there's a lot of negativity about it, and if you have to have one and you don't necessarily want one, you have to justify it." (PWFG)

"The media says it's women being too posh to push, and that it suits obstetricians, or women are too lazy. They push the view that if you have a caesarean section, you don't have to go through the pain." (FGPW)"

"There is huge information from the media that caesarean birth is safe. If you have it, you know when, the time, there's no labour, no risk of the baby dying in labour. You just have to look at [a recent] 'Sixty Minutes', report on a particular reporter who had an elective caesarean because of X, Y Z – there was nothing medical about x, y and z, it was all to fit in with her lifestyle." (FGPW)

An untrustworthy body

Modern antenatal care has created a hypervigilance in both expectant parents and health professionals. While antenatal screening tests and regular check ups are intended to reassure the mother that they are receiving health care that makes them and their babies safe, it can create an atmosphere of insecurity.

Group B Streptococcus infection (GBS)

Group B Streptococcus is the leading cause of neonatal early onset infection. Although rare (0.5-1.0/1000 births) it is a major public health problem due to the risk of death and illness in affected infants. This infection has been attributed with causing the death and disability of neonates per 1000 births in Australia. Identifying babies who are at risk of this infection has meant that women who rupture their membranes early, who are in preterm labour, who have a fever or have been identified as having a GBS infection in a previous pregnancy are given antibiotic therapy in labour. In addition depending on local policies many low risk women are screened routinely and found to have GBS.

The midwives had the most to say about this.

"f they're GBS positive [a streptococcus that can be in the vagina], this leads to a higher risk of infection to the baby so we are routinely swabbing vaginas at 36 wks and women swabbing their own, and if the swab comes back positive, then GBS is there then they need bung in hand or IV access and antibiotics.'

Lots more are getting antibiotics

We didn't use to do that. Now they say it's about 10%. Here it would be 70%.

It's high, really high.

It can be devastating and can lead to the death of a baby within six hours, but there's a very low incidence of death, mainly in babies who are compromised like prem babies and growth restricted babies.

It's a normal organism in the vagina and doesn't usually cause a problem, but now if they have it, the policy here is to give antibiotics in case their baby is affected by it.

Stats say that 1 in 4 women have it. For the babies that may get the infection, you can prevent a catastrophic situation but on the other side, how many babies have their gut flora disrupted because their mother had antibiotics while they were in labour.

The midwives in particular were concerned about the messages this screening sent to women about their bodies as a hostile place for the baby.

My savage vagina

So once again you're telling a woman your body is actually dangerous for your baby being born out of your vagina.

I had a call the other night from one woman, saying, 'I would normally stay home longer, but I think my waters have broken and I've got that really bad germ, so I need to come into hospital now'.

And coming into hospital early sets women up to failure to progress in labour, the whole cascade of potential interventions simply by presenting too early.

Then the baby has to have 24 hours observation so less women are going home early.

Who do women listen to?

Women stated they would be guided by professional advice from doctors, obstetricians and midwives. One midwife commented that all of the women in antenatal classes she had run said they would do what the doctor told them.

... in antenatal classes I will ask, 'If the doctor said you have to have a caesarean, would you say no?' They always say no. (Midwife)

I would assume medicos know more than I do. (Pregnant woman)

I am still like that. I still do what they (doctors??) say. (Pregnant woman)

I'm not a nurse and it's intimidating to think I can say no. (Pregnant woman)

In contrast, many of the women who informed this research wanted to be the one to make the decision about what kind of birth they had.

I'd be wanting to be part of the decision. I feel really strongly about that. (Pregnant woman)

Ideally, I'd want to be part of the discussion and include medical points of view and your own and your partner's. (Pregnant woman)

I wouldn't just let them decide. (Pregnant woman)

I'd like to think it was me making the decision and not being told. (Pregnant woman)

"The stats are so high for caesarean section, there's a lot of negativity about it, and if you have to have one and you don't necessarily want one, you have to justify it. She was breech. If you don't have caesarean section and just have natural birth, they don't want gory details then."(PWFG)

The women spoke about the different levels of communication they had with midwives as opposed to doctors and obstetricians. Perhaps, as one suggested, this is because midwives are mostly female and doctors and obstetricians are mostly male. The women described feeling more comfortable asking questions of the midwives. They described a two-level process whereby doctors and obstetricians gave them the facts and the options, and midwives gave them more detailed explanation.

Doctors and midwives are very different. The midwife will ask what you want to get out of it, but doctors sit there and say, 'Right, have you got questions?' Then they reel off everything they know. The midwife will ask you and then go through everything. I like that better. They know how to answer it to fit in with what we want. Maybe because they're mostly women and doctors are mostly male. (Pregnant woman)

I'd be the sort who'd want to be discussing it with my midwife. I've had experience with my sister's birth and the obstetrician was hard to work with. (Pregnant woman)

There's a lot of strong opinions around. You pick and choose what you want to take in. When I first went to the midwife, she was very much that it could be either way – caesarean section or vaginal. The registrar was very pro caesarean section. That put me under pressure. (Pregnant woman)

You certainly feel a bit dopey asking the doctor. I don't feel so dopey asking the midwife. You sit there thinking, 'I know she's answered this question a hundred times', but I feel comfortable asking her and I'd feel uncomfortable asking a doctor. (Pregnant woman)

My last one, I had no idea when we got pregnant so my dates got changed around. I was a newly wed and I thought, 'Who cares?' and the midwife got that, but the doctors said, 'You should have taken notice'. (Pregnant woman)

Midwives, too, spoke about the different communication style.

Women have wanted two appointments, one with the obstetrician and one with the midwife, for the obstetricians to handle the high risk stuff and the midwife to explain it all. They might be high risk and go to obstetricians who do all the tasks and then they want to come through us and talk about other issues. (Midwife)

If women become high risk they see obstetricians but do the debrief or reinterpret what the doctor has said with a midwife. (Midwife)

The midwife could also play the role of advocate for the woman within the hospital system.

> ... if you go through the Community Midwife Program, you have the one midwife and you don't have to see an obstetrician unless you want to. And the midwife advocates for you. One time, one of the obstetricians said something and the midwife said, 'Can you write that down in the notes please', so she didn't have to persuade every other obstetrician. It's little things like that [that are valuable because] you don't know what to ask for. (Pregnant woman)

After the first birth experience, the women had greater confidence in having a voice in birthing decisions.

> Before my last birth, I would have left it in medical hands, but now I'm not so confident and think a second opinion is a good thing. It should be my decision in the end. (Pregnant woman)

> It's easier for me to be empowered because I've been through it before. I know what to expect in a caesarean But when you go in with no idea, you just listen to whatever they tell you. (Pregnant woman)

> Although I've helped a lot of women as their birth partner, this is my first. I've seen doctors charge in and say one grumpy thing and you don't see them for hours. So makes me feel more assertive. (Pregnant woman)

Vaginal Birth after caesarean Section (VBAC)

The most recent report from the National Perinatal Statistics Unit: Australia's mothers and babies 2006 (AIHW 2008) stated that 84 per cent of women who had a caesarean section in the period 2003-2006 went on to have a another caesarean section.

The term for women who have previously given birth by caesarean section and then have a vaginal birth in their next pregnancy is 'VBAC' (vaginal birth after caesarean section). A collective effort by clinicians to work towards a normal birth in subsequent pregnancies for women who have a caesarean offers the greatest potential for reducing the rate of caesarean section.

> ... we were thinking of starting a campaign to encourage more vaginal births after caesarean section. If you look at statistics it's one of the main reasons our caesarean section rate is increasing so much. (Obstetrician 3)

> We need to rethink our caesarean section rate after caesarean section. We need to see all prima gravidas [and ask] why they're having a caesarean section because for mothers having first babies, if they have a caesarean section it affects all subsequent births. (Midwife)

As one obstetrician observed, there seem to be two distinct groups: women who had a caesarean section early in labour or as an elective, and those who had a long and arduous labour which ended in an emergency caesarean section. Mostly, women in the first group will want a vaginal birth in their next pregnancy, and mostly, women in the second group will opt for an elective caesarean section the second time through fear of repeating their first painful and frightening experience.

> These are the ones that had a probable recurrent cause like a big baby, and they're just as likely to have a big baby next time who'll get stuck again. For women who had a breech the first time, that is not likely to happen again. I give options, but don't advise either way. (Obstetrician 1)

> They felt they had a long and exhausting labour and ended with caesarean section and recovery didn't go well because of exhaustion and blood loss, and they heard other women had elective caesarean section, and went cruising through it because they had no exhaustion or blood loss. They would think, why not, I'm having a caesarean section as well. (Obstetrician 2)

> Some women are terrified of labouring before a caesarean. They don't want to hear VBAC. They say, 'I'm having a caesarean'. It's a common experience. (Midwife)

> There are some situations where you'll get someone who wants a vaginal birth the second time, but knowing the kinds of tears she had, you don't feel you can safely offer it. And you get the others, too, who ended up with a caesar for something that is very non-recurrent, they are progressing well in pregnancy, the baby's small and in the right position, and if they wants a caesar, you can point out how well they're going. They are all allowed to change their minds. No one is committed till they're on the operating table. (Obstetrician 1)

> ... most will want a vaginal birth next time, they feel they've missed out. (Obstetrician 1)

For some women though the sense of certainty makes caesarean appealing even if they were initially looking forward to a normal birth.

> My baby was breech 6 weeks before so I was told it has to be a caesarean. I bawled and bawled and felt cheated, but from what I've heard of natural births, I'm going to go for a caesar next time. I could stretch to put clothes up on the line. Knowing you're having a caesarean you can mentally prepare. (FMWB)

It appeared that women who had an unhappy experience of labour which ended in a caesarean section were motivated in their decision to opt for a caesarean section in subsequent pregnancies by fear. They wanted to avoid a repeat of the long, arduous labour, ultimately followed by surgery.

> ... they have had three days wait, a long dreary labour, they've been fully dilated for an hour, pushing, getting nowhere ... they are taken around for a Caesar. It's a difficult caesarean section but finally after three days they have a live baby. Even those who are happy and healed don't want to go through that again. (Obstetrician 1)

Women who had not endured the long labour before their caesarean section were more likely to speak about the effect of the caesarean section on them during the first weeks of the baby's life. They spoke of regretting not being able to spend the first hours with the baby and remembered feeling restricted in their activities around the home and with their children. For rural women, not being allowed to drive a car for six weeks can mean reliance on others.

> I've had two caesareans but having a natural birth and being able to do more things and driving would be good. (Pregnant woman)

> My little girl was breech so I had to have a caesarean. I didn't like being separated from my partner having the spinal block. And then I missed out on an hour after the child was born because you go to

recovery and you are in a blur. I didn't enjoy it. I don't know why people would ever choose caesarean section. (Pregnant woman)

My husband had the baby for an hour to himself. I missed out on that. I don't want to take it away but I want that too. I carried it for 9 months. (Pregnant woman)

My baby was stuck with his foot right down and they had to yank him out in a caesarean operation. He was in Melbourne for 3 days and I was stuck here because there were no beds for me in Melbourne. My husband went with my baby. (Pregnant woman)

... I was trying to get out of bed at 2 or 4 am. Your tummy is all stitched up and I'd have to try and get out of bed to feed the baby. (Pregnant woman)

It's like you didn't really have the baby. (Pregnant woman)

Not being able to lift my 2 year old after having a caesarean section is a real concern. (Pregnant woman)

It feels like you're pushing them away but you're not. There's only 22 months between my two. They always want to be lifted up and at that age, they want to jump all over you. (Pregnant woman)

I don't want to rely on others. I want to be able to do things. It gets you down because you're stuck in the house. I can't even put them in the pram and go for a walk. (Pregnant woman)

I've been scared of having the spinal block again. The first emergency caesarean I had epidural and couldn't remember anything till I woke the next day but I was numb from the neck down. When I had the spinal block it was from waist down. I know what's going to happen now and I'm scared. (Pregnant woman)

The scar scare

Once surgery has taken place on the uterus through caesarean section the integrity and strength of the muscles is somewhat compromised. The overall uterine rupture rate for all women has been calculated at (0.07%) and those with prior caesareans (0.43%) [10].

Irrespective of the very low actual chance of this happening to a woman the very nature of such a conversation raises a very real fear.

After caesarean section, with the next delivery there are risks, whether to go for vaginal birth when there is a scar. There is more risk having a birth after a caesarean section because there is a scar on your uterus and the scar tissue is weaker. There is a slightly higher chance of rupture of the uterus (OBS2)

…because there's a scar and we are reluctant to induce any woman who has a caesarean scar. (OBS2)

I was afraid of my scar rupturing during a vaginal birth. (FGM)

I was a bit worried being the third time because the scar was thin and I live an hour from Wang. I was a bit worried and excited at the same time.(FGM)

If you say I want a natural birth, they say, 'You've had a caesarean. I have to check where scar is', and that generates questions.(FGPW)

> I had a doctor explain in detail what a uterine scar rupturing looks like. Because I had a caesarean the first time and this time want a natural birth. This was at my 6 week check up.(FGPW)

Influence of family in VBAC

Whether a woman has a caesarean section as a VBAC seems to be influenced mostly by her own experiences in the first birth and then by a range of other factors, including her partner's preference, and the influence of family, friends.

> [My husband] wants me to have a caesarean section because he doesn't want to see me going through the pain and probably screaming at him. (Pregnant woman)

> Most decisions are being made by the women but not all. Men are involved to different degrees, mothers are involved to different degrees. (Obstetrician 1)

> One woman who was a very good candidate for VBAC and at booking, maybe even at the next visit she was open to that, then decided she was going to have caesarean because her husband said she may as well. I found the attitude difficult to cope with. She just chose the caesarean. I never got the opportunity to meet the husband till after the birth. In that situation, it was a done deal, I'd be wasting my breath, and it may have been counterproductive. (Midwife)

Influence of health professionals in VBAC

An important influence is the attitude of health professionals a woman interacts with during her second pregnancy. Obstetricians and midwives spoke of assessing each pregnancy in its own right before negotiating a birth plan with the woman, and carefully monitoring any changes. There was a great deal of commonality in the approach of these clinicians. Some caesarean sections are the result of a one-time problem which can be ruled out in subsequent pregnancies and any challenges presented by the caesarean section scar, such as tears or reduced options for induction, can be assessed.

> There are a small percentage of women who request a caesarean and obstetricians do a great job of counselling them. Their notes say she's requested a caesarean but there's no medical indication for it, they try to give her the facts, the pros and cons, and give her thinking time. Sometimes it does change their mind, it's powerful. (Midwife)

> When my baby was breech at 39 weeks, [my obstetrician] said, 'Unless he's your fifth child or you can give birth to a tram we won't let you try to birth naturally'. But this time, he said, 'I know where your scar is, I can get around that'. He's happy for me to try to birth vaginally. (Pregnant woman)

> [We have to give] reassurance that we would opt for caesarean sooner rather than later next time, and that she wouldn't labour in agony for hours if she did end up having a caesar after labour. (Midwife)

Mixed message in VBAC

Clinicians spoke about the frustration of working with a woman to reassure her that a vaginal birth is a safe option, only to have this quickly undone by the attitude of a colleague who speaks to the woman about potential dangers of giving birth vaginally after a caesarean section.

I had a doctor explain in detail what a uterine scar rupturing looks like because I had a caesarean the first time and this time want a natural birth. This was at my 6 week check up. (Pregnant woman)

I think occasionally birth attendants at the previous birth inadvertently say things that stick, that, 'baby's head was very moulded', 'lucky you had that caesarean section'. (Obstetrician 3??)

Sometimes you're a bit undermined at your own clinic, by colleagues. I could see a woman at the start of her pregnancy and we have the talk about her previous caesarean and get the file out and see what happened and have a talk about vaginal birth this time, but somewhere along the line you get the file out and discover that they saw a colleague in your clinic who was less encouraging so they start to get anxious. (Obstetrician 3??)

[I was surprised at] how much of the decision making was not in my control. I had to have a caesarean and I was given the opportunity for a vaginal birth for my third birth and they weren't supportive of that at all at the hospital. You were treated like a plague if you wanted to labour after a caesarean. (Mother)

Sometimes you're a bit undermined at your own clinic, by colleagues. I could see a woman at the start of her pregnancy and we have the talk about her previous caesarean and get the file out and see what happened and have a talk about vaginal birth this time, but somewhere along the line you get the file out and discover that they saw a colleague in your clinic who was less encouraging so they start to get anxious. (Obstetrician 3??)

I would feel better to [persuade a woman to have a vaginal birth] when I know I could personally go on caring for her ... It's always a shared care what we do here, and I might not be here. It's not a [guaranteed] continuity. (Obs 2)

Systemic communication problems regarding VBAC

One obstetrician spoke of the need to debrief women about their first caesarean section in the early months after their experience to increase the possibility that they will opt for a vaginal birth next time. He identified a systemic barrier to this happening in the public system. As an obstetrician, he will not see the woman after her birth. She will return to her GP for the postnatal check. Communication to the GP about the birth is through the hospital registrar – the least experienced clinician involved – and is often a 'tick-box' style form. Improved communication to women and their GPs that the woman is unlikely to need a caesarean section in subsequent births long before they are even pregnant a second time, could be an effective strategy to reduce caesarean section rates. The notion of formally debriefing a woman and her partner after a difficult birth was mentioned by both midwives and doctors.

It would be good to talk to women a bit closer to the original birth where they experienced a caesarean and not waiting till they get pregnant again and they're halfway through the next pregnancy. They need to think about options soon after the first birth. (Midwife)

... it's more common for [women having had one caesarean section] to want to have a caesarean section than not want to and even though we know it's quite safe for them to labour next time, they have preconceived ideas before they see us in the clinic in their next pregnancy. (Obstetrician 3)

> I think frequently we don't debrief people adequately after a caesarean section or instrument delivery about what's likely to happen next time. What we can say is, 'You're probably not going to have these problems next time'. When we do debrief, they have a new baby and they're tired recovering from a caesarean section. I don't know how much they take in, and we don't have systems to get them back later. (Obstetrician 3)
>
> Everyone gets a discharge letter sent to GP but that's generated by resident who is the most junior person in the team and frequently has little insight, so GPs don't necessarily get the appropriate information. They are computer generated mostly so letters tend to me to have little more than yes, no answers. (Obstetrician 3)

Discussion

Our informants were well aware that post war history has seen a fantastic improvement in the odds of survival during child birth for women and babies in resource rich countries such as Australia. This has come about due to a combination of a better standard of living and medical technologies such as antibiotic therapy, safe surgical and anaesthetic techniques and neonatal intensive care. While the rise in the rate of caesarean section during the period 1940 -1980 was commensurate with the improvements in mortality and morbidity there was some discomfort in the fact that there has been little change in outcome for mothers and babies but an exponential rise in the CS rate which shows no sign of plateauing.

It's not surprising that in terms of changes to birthing practices this rise in CS is foremost in the minds of clinicians and new parents. Debate rages around the world about this issue from the mainstream media and the academic press alike. Savage[3] has found that since 1970 Medline lists almost 8,000 articles with the key words 'caesarean section' over 27,000 with 'cesarean section'. If one was to type the same key words into 'Google' 4,870,000 and 1,750,000 hits come up respectively!

While the doctors and midwives discussed the technologies which have made birth different and often safer they leant considerable weight to discussing the societal and cultural changes that have impacted on their experience of caring for mothers, babies and fathers. Their comments on applying rules to the length of labour and reacting to suspicious CTG traces as creating anxiety in the labour room resonated with a recent editorial in '*Women and Birth'* [11] . Here Jennifer Fenwick reflected on the work of Davis Floyd [12] and the "one punch two punch theory"

"Take a highly successful natural process- a woman's labour and birth- render it dysfunctional with technology. Apply rules to the length of the pregnancy. Promote hospital birth as the only safe environment. Divide labour into stages…Apply protocols and guidelines without individuality..and when they become so anxious and fearful that their labours slow, stall or fail to start…"

Davis- Floyd (1994) [12]

Midwives in particular seemed very concerned about the impact that intense medical surveillance had on undermining trust women had in their own bodies. They described the tension between

subscribing to the medical model and maintaining the integrity of the natural birthing process. A sentiment also explored by Fenwick [11].

The construct of risk was raised by everyone. Women in particular commented on decision making and the difficulties they encountered in interpreting information and the way it was delivered from health professionals. This made it hard for them to determine risk because to some extent everything is risky. This echoes work by such authors as Goodall et al (2009)[13] who described four themes when interviewing women about decision making for subsequent childbirth after a caesarean section. The participants in Goodall's research said they lacked relevant knowledge to make an informed choice; they were given unhelpful probalistic information; they received latent communication from health professionals and their ultimate perceived response was to relinquish decision making control to the health professional.

Inherent in the discourse of risk is the very visceral experience of fear. Our informants discussed this at length. Fear of catastrophe has a permanent seat in the subconscious of the clinicians and parents alike. Apart from fear of the worst outcome (death to mother or baby) there were descriptions of more subtle worries- fear of failure to labour and birth well, fear of repeating a bad labour if their first experience was not good from the women, failure to give the 'right 'kind of support from the men, failure to adequately shepherd women though the birth experience from the midwives and fear of reading the essence of a situation and adequately communicating this from the obstetricians. The academic literature is growing substantially on these issues [14-19].

Interesting in this research was the very clear message from pregnant women and new parents that litigation would be a last resort for them if the birth did go wrong. There was a strong sense of trust and respect for the intentions of the clinical staff. This was at odds with the nagging fear that clinicians especially doctors have of being sued for a poor outcome but the knowledge of parent's probably does little to reassure them [20].

No women in this cohort would actively choose to have a CS for their first birth. This was echoed by the clinicians who saw little evidence of 'caesaer on demand'. Women who had a difficult first labour and subsequent caesarean section were however inclined to elect CS in their next pregnancy. A finding refelected very much by other research [21,22] . The fathers too who informed this work very much saw labour and vaginal birth as the natural and desired process.

An effort to avoid caesarean section in the first place through primary health measures such as reducing obesitiy, treating each labouring woman as an individual rather than slavishly adhering to constructed rules, combined with a desire to work collaboratively in supporting women to labour in births subsequent to a CS was seen by the clincians as important in addressing the local rate of caesarean section. In addition clinicians, pregnant women and new mothers alike would like to see a realignment of the power base from where the trainee registrar seems to have an inordinate say in the mangement of the pregnancy and labour.This sentiment is echoed by many in the academic literatue but most eloquently by Savage [3] who also believes the will is there to reduce the CS rate in if we all work together.

Conclusion

The findings of this research mirror much of the extant literature on preferred modes of childbirth. While in the eyes of these informants, caesarean section has been normalised as legitimate and safe, vaginal birth remains the most desired means for a baby to be born.

The informants of this work have described changes in culture and a societal intolerance of uncertainty as important drivers in the rise of caesarean section rate. Electronic foetal monitoring and regular antenatal checks from a variety of clinicians have imposed a vigilance that doesn't always serve to reassure the mother. The demeanour and language of the clinician is powerful in serving to give women confidence in birth or conversely contribute to their fear and uncertainty.

Doctors, midwives, pregnant women, mothers and fathers shared many similar views and respectfully considered the role and opinion of each other. Given this mutual regard it would seem probable that they could work together to confidently increase the numbers of women successfully having a VBAC.

Father 1: Mark, Father 2: Juan Father 3: Tim

Ob 1: CP Ob 2 JK; Ob 3 LF

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