Have We Lost Sight of the Women? An Observational Study About Normality-Centred Care in Australian Maternity Services.

Running Title: Have we lost sight of the women?

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ABSTRACT

Objective

- Prioritising normal birth has led to harm in some instances in the UK
- Australian organisations have also promoted normal birth in maternity practice
- The negative impact of normal birth appears less well understood in Australia
- The study explores this impact of normal birth promotion and the quality of clinical incident investigations

Design

- Survey-based research design

Setting

- Online survey

Population or Sample

- Australian maternity health care providers

Methods

- Open and close-ended questions on the survey
- The survey received 1278 responses
- Data analysed using SPSS software

Main Outcome Measures

- Perceptions on bias against or delay in interventions
- Perceptions on systemic attempts to reduce caesarean rates
- Perceptions on clinical incident investigations and the engagement of women in these processes

Results

- Promoting normal birth may by introduce bias against or delay interventions
- Attempts to reduce caesarean section rates may reduce the agency of the woman to choose how she births
- Incident investigations appear to be independent and improve outcomes for mothers and babies
- Women with birth trauma appear to lack support and follow up postnatally

Conclusions

- Current regulatory standards for maternity services may need to be re-evaluated
- Key performance indicators for maternity services need to change to reflect core ethical and legal obligations around informed consent

Funding

- No conflicts of interest to declare.

Keywords

- Normal birth, caesarean, intervention, clinical investigations

INTRODUCTION

Birth is increasingly dichotomised into the wellness-based[1] 'normal' versus 'medicalised' birth. In this article, we define the notion of 'normality-centred' care as the organisational care provision offered to a pregnant woman within a model of constructed wellness that realigns the care priority locus from the woman in her natural state to an ideal, sometimes illusory notion of her.

The 'Campaign for Normal Birth' in the UK was instrumental in contextualising normal birth as a 'key political agenda item'.[2] The cultural prioritisation of 'normal' is now directly implicated as having caused harm. The Morecambe Bay investigation[3] drew a defining link between poor outcomes there and 'the national agenda as dictated at the time…to uphold normality', amongst other systemic issues. A recent review[4] of maternity services at Shrewsbury unearthed a 'culture there, of keeping caesarean section rates low, because this was perceived as the essence of good maternity care' without 'consideration of whether this culture contributed to unnecessary harm'.

The 'Campaign for Normal Birth' crystallised the idea of normal birth as a marker of quality in maternity services. Australia's 'Towards Normal Birth' policy in New South Wales is a case example of the cultural diffusion of this idea across jurisdictions. The question however lingers – do healthcare systems adopt a 'bias against complexity' based on such 'normalisation' of pregnancy?[5]

We conducted a national survey of maternity care providers to explore opinions about the potential negative impact of policies promoting normal birth or lowering intervention rates, the quality of maternity services investigations, and support provided to staff and women through such processes. Our study explores the interdisciplinary consensus or differences to understand whether concerns about an emphasis on normal birth shifting the focus away from woman-centred care are borne out across Australia and merit further attention.

METHODS

This is the largest ever multidisciplinary survey of its kind in Australia that has attempted to study the negative implications of 'normality-centred' care, a subject of debate[6] here for some time now. This was done as part of a larger study looking at informed consent and refusal in childbirth.

The study is based on a survey research design[7] to help obtain data across a broad sample size. Ethics approval was granted by Townsville Hospital and Health Service Human Research Ethics Committee - Reference number HREC/18/QTHS/88. We have not sought responses from patients through this survey.

The sample population included maternity care providers affiliated with RANZCOG (approximately 1000 Fellows, subspecialists, GP obstetricians, and trainees) and ACM (approximately 5000 registered midwives and midwifery students) across Australia.

The survey was piloted amongst maternity care clinicians to identify how well respondents understood the questions, to identify potential errors, and to look for consistency in responses. The online survey was constructed using 31 close-ended and open-ended questions (no question/page logic applied) and divided into main sections that collected data on normal birth, caesarean section, informed consent, and informed refusal. This article looks at results obtained from the normal birth and caesarean section portions of the survey.

The questions asked in the survey drew from some aspects of the Kirkup report[2]. We believe the references to a 'lethal mix'[6] of failings in that report (a contributor to which was a culture of 'normal birth at any cost') hold implications for practice across the wider maternity service sector, including that in Australia. The questions on clinical investigations were based upon a thematic analysis published by NHS Resolution.[8]

The response options offered were in multiple-choice or Likert scale formats. To avoid bias, an equal number of positive and negative responses were provided with the Likert scale format questions. The open-ended questions were designed to elicit reflections unable to be expressed through the other questions.

Data were analysed using statistical software SPSS 23. Continuous variables were tested for normality and based on the outcome of the test, parametric or non-parametric analyses of the data will be undertaken. The chi-squared analysis was performed for determining associations between categorical variables. Multivariate regression model logistic regression was used to determine factors leading to obtaining consent among health professionals. A p-value of <0.05 was considered statistically significant. For the obstetric cohort, 278 responses set the margin of error at 5% with a 95% confidence interval. For the midwifery cohort, 357 responses set the margin of error at 5% with a 95% confidence interval.

RESULTS

The survey received 1278 responses with an 83% completion rate. 7 responses (with a current role specified as 'other') were unable to be placed into either midwifery or obstetric cohorts and were not included in the final results. Of the 1271 responses that were analysed for the final results, 851 (67%) were from the obstetric group and 420 (33%) were from the midwifery group.

Table 1 outlines the health care provider awareness of guidelines related to normal birth and caesarean delivery by maternal request. Table 2 outlines the questions related to the patient safety implications that were being studied as being impacted by normal-centred practice.

There was overwhelming consensus within the obstetric group in their belief that women (93.8%) and clinicians (81.4%) would likely develop a bias against interventions from the promotion of normal birth. Greater than half of the midwifery group shared similar beliefs concerning these questions. This proportional difference between the two groups may

partly reflect how normality remains a defining characteristic of the midwifery scope of practice.

A significant majority of respondents (86.6%) from the obstetric cohort and greater than a third of all midwifery respondents believed that delays to intervention occurred on account of promotion of normal birth.

The survey revealed broad agreement amongst respondents from both obstetrics and midwifery groups that caesarean sections, as a key performance indicator of maternity services, had sometimes or frequently led to maternal requests being discouraged, increased rates of assisted vaginal births had increased emphasis on promoting vaginal birth after caesarean sections.

Remarkably, the survey results noted a significant difference in the beliefs expressed by the interdisciplinary respondents over the question of a culture of vaginal births 'at all costs' leading to poor outcomes for mothers and babies. This may even appear contrary to the belief expressed by a greater proportion of midwifery respondents of an increase in assisted vaginal births.

Table 3 outlines the questions related to the postnatal aspect of woman-centred care. It is heartening to note that the survey results suggest a majority of respondents across both groups believe that clinical incident investigations across Australia are independent and that recommendations from these investigations have resulted in improved outcomes for mothers and babies. Nearly half of all respondents however believe that women are never or rarely adequately engaged in these investigations. It is of concern though, that nearly a third of the obstetric group and half of the midwifery group also believed women who have suffered birth trauma are not given adequate support.

DISCUSSION

Main Findings

This study has found that providers believe that the promotion of normal birth presents challenges to both patient safety and woman-centred care that need to be acknowledged and addressed. The discussion focuses on four particular issues in the survey:

Bias against interventions

The definition[9] of a midwife includes promotion and advocacy 'for non-intervention in normal childbirth'. Such advocacy conflicts with the fundamental obligation to offer unbiased information 'informed by scientific evidence'[10]. As an illustration, should a clinician discourage a low-risk woman's request *for* induction of labour based on an ideological commitment to non-intervention, despite evidence[11] that shows important benefits?

There is already evidence of how directives promoting passive management of labour may, possibly, have led to higher rates of obstetric anal sphincter injuries in Sydney.[12] If

the experience in other systems[13] is anything to go by, the National Core Maternity Indicators[14] in Australia (used to benchmark maternity units nationally) risk being hijacked to meet ideological targets with little interdisciplinary consensus and even lesser scientific credibility.

Cultural bias against interventions compromises both ethical practice and patient safety. Women are effectively labelled as normal or not normal and 'made to feel failures if they do not have a 'normal' birth'.[15] The woman or her clinician may also de-risk the pregnancy to stay 'normal' by disregarding best practice recommendations thus compromising the decisions of where, when, or how to give birth.

Delay in interventions

Delays in interventions are a well-recognised patient safety risk as noted in multiple national reports[8, 16, 17, 18] from the United Kingdom. Situational awareness and 'escalation'[19] involves a complex process requiring a 'combination of clinical, behavioural, and logistical steps to correctly identify and deliver urgent care'. A multitude of factors such as inadequate staffing, poor infrastructure, staff training, and acuity of workload can all contribute to delays.

A failure to escalate for further opinion, when risk develops during pregnancy or labour, effectively compromises safety and multidisciplinary collaboration. As noted by Kirkup[3], the 'evidence of midwives overzealously guarding their patients from obstetric involvement', is just one example of this. We now know that a hospital held up as a 'beacon of excellence'[20] for its 'unusually low' caesarean rate can end up as a cautionary tale on failed regulation.[21] It cannot be assumed that Australia is immune[22] to such malignant cultural influences.

Caesarean sections / Vaginal births 'at all costs'

The findings related to maternal request caesarean sections are surprising given the unambiguous national guidance[23] in Australia in support of it. Consumer advocacy for caesarean choice in Australia appears tepid[24] in comparison to the grassroots activism[25] seen elsewhere. This, despite studies[26,27] showing that some women are open to the idea of an increased caesarean section rate even for limited fetal benefits. Future research is needed to robustly investigate any conflict of interest claims[28] to help ensure such groups remain representative of a wide spectrum of consumer sentiment.

Whilst it is acknowledged that assisted vaginal births have only increased marginally, it does not detract from the crude regulatory attempts in the last decade, as with 'Toward Normal Birth', to mandate increased vaginal birth targets[29]. Such social experiments have largely failed to acknowledge clinician concerns about increasing rates of complex pregnancies or the body of evidence around damage[30,31,32] caused by instrumental births.

Incident investigations, birth trauma, and woman-centredness

Birth trauma is common in Australia and affects up to one in three women.[33] A recent submission[34] to the UK parliament suggests that 'most harm, most litigation, most brain

damage, and most maternal injury arises as a consequence of traumatic vaginal birth' and not from an elective caesarean section.

The results from this survey appear to mirror the message from a recent review of the Open Disclosure Framework[35] which notes that Australian health organisations were 'at different levels of maturity with respect to implementation of open disclosure, and there were inconsistencies with how the Framework was translated into practice'. One key issue identified there as a priority for service improvement relates to 'support for people who have experienced harm, their support people, and the health workforce, and ensuring that this is provided at the right time and that it meets their needs and expectations.'

Interpretation

The study has identified that a focus on normal birth in Australian practice has possibly caused harm and loss of autonomy for women. The study has also exposed the tensions[36] that exist at a policy level, where well-intentioned attempts to ensure patient protection may be perversely neutralised through the promotion of normality-centric regulations. The findings from this study ultimately appear to reinforce an argument for written informed consent in vaginal birth as a means of protecting maternal autonomy.

Strengths and Limitations

The authors advise caution with the interpretation of results from this observational study given the relatively low response rates to the survey, despite attempts to reduce the risk of selection bias by approaching respondents across both professions. It remains a ground-breaking study given this has not been looked at previously in an Australian context and holds valuable lessons for future policy and practice.

Maternity care in Australia functions safely and consistently at a level where high-risk events are uncommon. When these occur, the incident mechanisms in each state capture such data variably. Another layer of complexity arises from the guidelines in Australia being heavily jurisdiction-dependent. Such variation in practice makes it is hard to draw accurate generalisations about the results.

CONCLUSION

'Normal birth' is a term that reinforces the power of a woman's ability to birth naturally and weaves a potent anti-intervention narrative into this constructed myth. Lady Hale in her acerbic critique[37] on values and choices in childbirth says 'It looks like a judgment that vaginal delivery is in some way morally preferable to a caesarean section: so much so that it justifies depriving the pregnant woman of the information needed for her to make a free choice in the matter'.

This survey raises concerns, that the Australian system risks perpetuating normality-centred care through the regulatory tyranny of performance indicators influencing clinical counselling and decisions. We lose sight of the women somewhere between robust

advocacy of policy that supports normal birth and the uncritical ingurgitation of it into clinical practice.

DECLARATIONS

Disclosure of interests

No relevant financial, personal, political, intellectual, or religious interests.

Contribution to authorship

Dr Jay Iyer contributed to the concept and design of questionnaire. Dr Kaveshan Pather has helped with the article design and bibliography. Dr Usama Shahid has helped with the review of the manuscript.

Details of ethics approval

We confirm that this research has been carried out after ethics approval was granted (Townsville Hospital and Health Service Human Research Ethics Committee Reference number HREC/18/QTHS/88) on 30.05.2018.

Funding

No funding has been sought towards this project

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LEGENDS

Table 1: Health carer awareness of guidelines

Table 2: Normal-centred care and patient safety implications

Table 3: Clinical investigations into poor outcomes