

Dignity in Childbirth

THE DIGNITY SURVEY 2013: WOMEN'S AND
MIDWIVES' EXPERIENCES OF UK MATERNITY CARE

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Dignity in Childbirth: The Dignity Survey 2013: Women's and midwives' experiences of dignity in UK maternity care

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Introduction

'A woman's relationship with her maternity providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma. Either way, women's memories of their childbearing experiences stay with them for a lifetime and are often shared with other women, contributing to a climate of confidence or doubt around childbearing.'

White Ribbon Alliance, Respectful Maternity Care, 2011

Promoting dignity in healthcare has become an overriding imperative for healthcare professionals and policymakers alike. But what does it mean for women receiving maternity care? While the focus of human rights in the NHS is often on end of life care, human rights values are similarly fundamental to care for women, their babies and their partners at the start of life.

Dignity encompasses the twin ideals of respect and autonomy. It resonates loudly in the maternity context, where women are often vulnerable and exposed, both physically and emotionally. Respectful care and respect for women's autonomous choices are essential to positive maternity experiences and long-term health. They are also grounded in the legal obligations placed on the NHS by the Human Rights Act 1998 to respect individuals' dignity and rights under the European Convention on Human Rights.

There has never been a large-scale maternity survey focusing exclusively on dignity-related issues. While the National Maternity Survey by the Care Quality Commission poses a limited number of questions about respectful care and recent research by the National Federation for Women's Institutes and NCT asked about choice relating to place of birth, Birthrights wanted to gain a fuller picture of UK women's experiences of dignity during their births.

We commissioned a survey on the parenting website, Mumsnet, of women who had given birth in the last 2 years. Our questions focused on choice and respect. Over 1,100 women responded. Our results reveal that many women still do not receive respectful care or choice in childbirth. Only half of the women we surveyed had the birth they wanted. The majority believed that their childbirth experiences affected their self-image, and relationships with their baby and their partner. A significant proportion of these women believed that the effect was negative. We set out the results in the first part of this report.

Dignity in childbirth is largely dependent on the care that women receive from their professional caregivers. We sought the views of midwives on their perspectives and experience of dignity during birth. They described the challenges that they faced to safeguarding women's dignity as a consequence of staffing shortages and inadequate training. Our findings are summarised in the second part of this report.

Birthrights believes that understanding, embedding and monitoring dignity in maternity care has the potential to make a real difference to women's experiences of pregnancy and childbirth. We aspire to lead the discussion on dignified treatment in maternity care.

Birthrights, October 2013

Part I: The Dignity Survey 2013

Methodology

In September 2013, the parenting website, Mumsnet, hosted a survey about women's experiences of childbirth on its online surveys page. Responses were collected using an online questionnaire developed by Birthrights and Mumsnet. It was open to any woman who had given birth in the last 2 years. Respondents answered multiple choice questions about their most recent birth experience and were given an opportunity to provide further details in a free-text box at the end of the survey. Quotes cited in the findings below are taken from the comments in the free-text boxes.

The survey questions reflected themes that have been identified in existing research on dignity in healthcare. The themes we identified included choice, control, compassion, communication, kindness and respect. The questions also reflected the principles of respectful care set out in the White Ribbon Alliance Respectful Maternity Care Charter. The questions were designed to avoid duplication with research already undertaken by the National Federation of Women's Institutes (NFWI) and NCT earlier in 2013.

The sample

Over 1,100 women completed the survey. 40% of respondents were first-time mothers and 60% were second-time or more mothers. 98% received NHS maternity care.

64% of respondents had spontaneous vaginal births, 14% had instrumental births and 21% had a cesarean section (CS). We have chosen throughout this report to refer to types of births as: spontaneous vaginal, instrumental and CS. The CS rate was slightly lower than the national average of

25% and the instrumental birth rate accords with the national average of 13%.

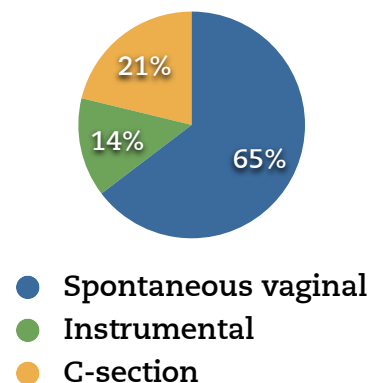
We asked women where they gave birth. 77% gave birth in hospital, 8% in a birth centre, either stand-alone or an alongside unit, and 13% gave birth in their own home. The home birth rate was significantly higher than the national average of around 2%. We removed the responses of women who had their babies at home from the findings below on the grounds that the experiences of women who give birth at home will not be typical of the general population. When home births were removed, the sample size was reduced to 977.

There was a wide regional spread of respondents. The largest number of respondents came from the north (21%) and south-east (19%) of England and London (16%). Scotland and Wales provided 8% and 3% of responses respectively.

We asked demographic questions about age and ethnicity. The largest number of respondents (41%) were aged between 30-34. A quarter (23%) were aged between 25-29 and a quarter (25%) between 35-39.

The sample was relatively ethnically homogenous. 94% of respondents were white, the remainder were mixed race, Asian, black or preferred not to specify their ethnic origin. We did not ask about respondents' income. We asked women whether they considered themselves to have a disability. 37 (3%) stated that they did.

Respondents by type of birth



Our findings

How women felt about their births

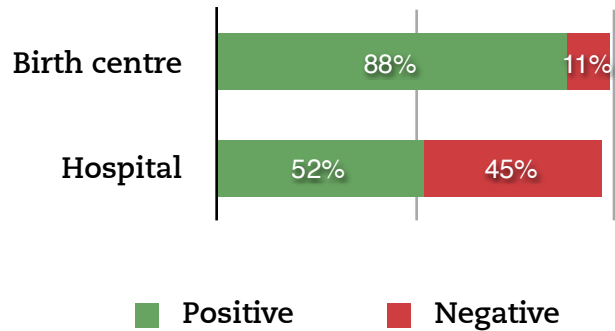
We asked women about the impact that their experience of childbirth had on their feelings about themselves, their relationship with their baby and with their partner.

Nearly two thirds of women (63%) felt their baby's birth affected how they felt about themselves. Of those women 55% felt the impact was positive and 41% felt the impact was negative. The negative impact rose to 73% of respondents who had instrumental births and 69% of respondents who had a CS. Only 11% of respondents who gave birth in birth centres felt that their birth experience had a negative impact on their self-image.

Almost half of women felt that the birth affected their relationship with their baby. Of those women, 22% felt the impact was negative. The negative impact was higher for first-time mothers (38%). Again, it rose for women who had an instrumental birth (59%) or a CS (38%). Only 4% of respondents who gave birth in birth centres reported a negative impact on their relationship with their baby.

Similar responses were received in relation to women's feelings about their relationship with their partner. 26% of respondents

How did your experience of childbirth affect your feelings about yourself? (by place of birth)



overall felt childbirth had a negative impact. The figure was higher for instrumental births (55%), CSs (37%) and first-time mothers (31%).

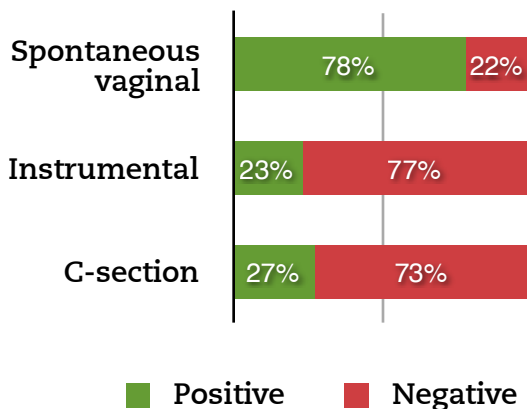
Over half of women said that childbirth affected their desire to have more children. Half of those women (52%) felt that their birth experience led to positive feelings about having children in the future, while 42% felt it had a negative impact. 50% of first-time mothers were put off having future children, 76% of respondents who experienced an instrumental birth and 61% who had a CS. 83% of respondents who gave birth in a birth centre felt positively about having children in the future.

Choice in childbirth

We asked women whether they agreed with the statement: 'I had the birth I wanted'. Half (50%) said that they agreed, 37% said that they disagreed and 13% neither agreed nor disagreed.

A greater proportion of women who experienced vaginal births reported that they had the birth that they wanted (66%) compared to 14% of women who had an instrumental birth and 36% of women who had a CS. 33% of first-time mothers reported that they had the birth they wanted compared to 63% of women having subsequent babies.

How did your experience of childbirth affect your feelings about yourself? (by type of birth)



26% of respondents reported that they did not have a choice about where to give birth, i.e. in a hospital, a birth centre or at home. This accords with the NFWI and NCT research which showed that only 12% of women had a full four choices of where to give birth (hospital, home, stand-alone birth centre or alongside birth centre).

Choice of place of birth varied by age of the woman. 33% of respondents over 35 said that they were not offered a choice of place of birth.

It is important that women are given information about their options in childbirth in order to make informed decisions and give informed consent to medical examinations or procedures. 21% of respondents reported that they were not given adequate information by midwives or other medical staff about their choices about their birth.

'The birth itself was in a respectful and supportive environment. But I wish I had been given more information about induction before I accepted one.'

The figures were higher for women who had an instrumental birth (26%) or a CS (25%). Our small sample of disabled respondents reported receiving inadequate information about their choices more often than the average respondent (13 of the 32 disabled women who answered the question).

A significant proportion of women reported dissatisfaction with choice and availability of pain relief. 10% of respondents overall were unhappy with the choice of pain relief. This rose to 18% of respondents who had instrumental births. Only 1% of respondents who gave birth in birth centres were unhappy with the choice of pain relief.

15% of respondents overall were unhappy with the availability of pain relief. For women experiencing instrumental births this rose to 23%. Disabled respondents said they were unhappier with the availability of

pain relief more often than the average respondent (11 of the 31 disabled women who answered the question).

We asked women whether they were happy or unhappy with their ability to choose their position in labour. 58% of respondents overall were happy with the choice of position in labour. This figure was significantly higher (89%) in birth centres than in hospitals (54%). Only half (52%) of first-time mothers were happy with the choice of position.

Control in childbirth

Research has shown that feeling in control during childbirth is associated with positive feelings about birth experiences, while women who do not feel in control of their birth have higher levels of dissatisfaction and may experience long-term psychological trauma (Gibbins and Thomson 2001; Waldenstöm 2004).

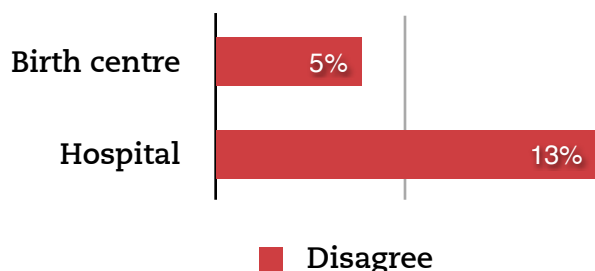
We asked women whether they felt in control of their births. 57% of respondents said that they did. This figure was lower for first-time mothers (45%). It was significantly higher for women who gave birth in a birth centre (87%) than in hospital (54%).

Consent

Obtaining a person's consent to medical examinations and procedures is a legal requirement. Where a woman is conscious and has mental capacity, there is no justification for failing to obtain her consent. In order for consent to be considered valid, a woman will need to have been given information about the procedure in question.

Overall, 12% of respondents considered that they had not given their consent to examinations or procedures. Respondents said that consent was obtained more frequently in birth centres than in hospitals.

I was asked if I agreed to each examination or procedure before it took place (by place of birth)

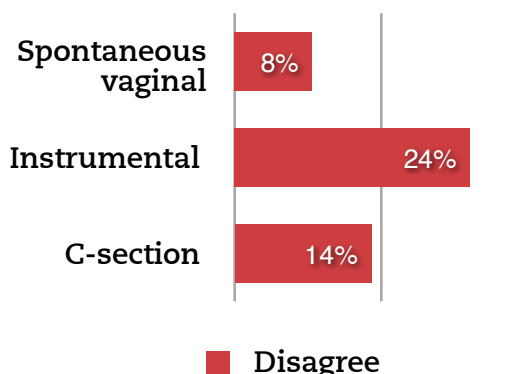


93% of respondents considered that their consent had been obtained before examinations and procedures in birth centres, while 77% of respondents reported that their consent had been obtained in hospital.

It was more common for consent not to be obtained from first-time mothers (16%) and for women who had an instrumental birth (24%). Failure to obtain consent was only slightly higher for women who had a CS (14%).

Respondents gave similar answers to the question about whether information had been provided before an examination or procedure. 11% of respondents overall considered that they had not been given information about each examination or procedure before it had been performed. This figure was higher for first-time mothers (15%) and in relation to instrumental births (23%).

I was asked if I agreed to each examination or procedure before it took place (by type of birth)



Respectful care

Caring and respectful relationships with healthcare professionals can make the difference between a positive and a negative birth experience, but the basic principles of respectful treatment are sometimes neglected in large-scale healthcare facilities – a problem highlighted by the recent NHS Mid Staffordshire Trust report. We asked women a variety of questions designed to elicit their experiences of respectful care.

In answer to the general question - did you feel respected by midwives and other medical staff? - 82% of respondents agreed. The figure was lower in London (73%). It was also lower for women who had an instrumental birth (74%).

‘It was wonderful. Midwives supportive when asked, respectful and distant. No one touched my baby until I invited them to.’

We asked whether healthcare professionals always introduced themselves. 20% of respondents said that they did not. Again, the figure was higher in London (26%).

The majority of women (86%) reported that healthcare professionals spoke to them in a kind and friendly way. Asked whether healthcare professionals listened to them, 73% of respondents agreed that they did. Women in London felt that they were listened to less often (68%).

‘I felt like some of the midwives and doctors didn’t listen to me or care what I wanted and when I got upset or scared they didn’t have time for that.’

Privacy is a fundamental aspect of respectful care. We asked respondents whether they felt that their privacy had been respected by health professionals. Overall, 83% of respondents said that it had. The figure was lower in London (76%) and for women who had instrumental births (72%).

In answer to the question whether respondents felt looked after by health professionals, the large majority of women agreed that they did (84%). Similarly, the majority of women (79%) felt safe during their births, though 20% of respondents who experienced an instrumental birth did not feel safe, compared to 8% of respondents who had vaginal births and 15% of CS births. Only 2% of respondents who gave birth in a birth centre did not feel safe.

Home birth

We removed figures relating to the experiences of home birth women from the findings above. Analysis of those figures reveals higher levels of satisfaction with care than for women who gave birth in hospital. For example, of those women who reported an effect on their relationship with their baby, 96% of respondents who gave birth at home felt the birth experience had a positive effect. 90% of respondents felt in control of their birth experience at home. However, satisfaction with choice and availability of pain relief was lower at home than in birth centres (65% were happy with choice, 61% were happy with availability).

Post-natal care

'My birth experience was fine, my postnatal experience is what let the whole experience down.'

The survey did not ask about women's experiences of post-natal care. We are aware from the research conducted by the NFWI and NCT in 2013 that post-natal care in the UK is highly variable and fragmented and many women have very poor experiences of care after their baby is born. This was supported by a significant number of comments that women made in the free-text box in our survey. Women's experience of dignity during post-natal care requires further investigation.

'The care during giving birth was excellent. However the care after giving birth was terrible, ruining the whole birthing experience.'

Survey conclusions

The Birthrights Dignity Survey paints a mixed picture of maternity care in the UK. The majority of respondents were satisfied with the care that they received. Overall, respondents reported relatively low levels of unkindness, they felt respected during their births and believed that health professionals listened to them. However, there was significant variation in choice and respectful care reported by women depending in particular on type and place of birth.

The experience of respondents who had an instrumental birth was noteworthy. These women reported significantly higher rates of disrespectful treatment. They also reported greater loss of choice and control. The figures relating to consent for instrumental births suggest that forceps and ventouse are frequently being used without proper explanation or consent being obtained.

While women who had a CS also reported less satisfaction with their care overall, the rates were not as high as those for instrumental births. Reasons for the high levels of disrespect and dissatisfaction in the among women who have instrumental births need to be investigated further.

From our research, it is evident that there is a disparity between women's experiences in birth centres, both stand-alone and alongside units, and hospitals. Women who gave birth in birth centres consistently reported more respectful care and greater choice and control than women who gave birth in hospitals.

Disabled respondents reported less choice and control over their birth experience. While the sample size was small, the results

accord with existing research on the limits on choice for disabled women (Redshaw, Malouf, Gao and Gray, 2013). Our findings suggest that further research should be undertaken into improving disabled women's experience of childbirth.

The majority of women felt that their experience of childbirth had an impact on their feelings about themselves and their relationships with their babies and partners.

A positive impact correlated with spontaneous vaginal births and giving birth in a birth centres. A negative impact correlated strongly with experiencing an instrumental birth.

The impact of childbirth on early motherhood needs to be explored further with a particular focus on the effects of choice, control and respectful care on women's experiences.

Part II: Midwives' perspectives on dignity in childbirth

Methodology

Birthrights recruited an independent social researcher to conduct qualitative interviews with midwives on the subject of dignity in childbirth. Despite increasing interest in human rights values in healthcare, there has so far been limited research into midwives' perceptions of dignity.

All women in the UK receiving NHS maternity care will interact with a midwife at some point during their pregnancies and births. For low-risk women, midwives may be the only care providers that they encounter. For this reason, Birthrights chose to focus this research project on midwifery rather than obstetric perspectives.

The sample

We sought to identify as broad as possible a range of factors that might be relevant to the question of dignity in childbirth. Midwives were therefore recruited from a range of roles, birth settings and locations in England. They all worked in the NHS, but some had previous experience as independent midwives.

A convenience/ease of access approach was used in recruiting the sample. A request for volunteers to take part in the research was sent to the Royal College of Midwives and distributed via its email lists. The information was then disseminated within the midwifery community via facebook groups and twitter. 10 volunteers were selected on a first-come-first serve basis with regard to the sampling criteria.

Recruitment and interviewing took place in a 2 month time period between late June and mid August 2013 and a single in-depth interview was conducted with each

participant selected. Student midwives were invited to take part in a focus group discussion. A group of 6 final year student midwives was recruited via Student Midwife Net.

The midwives' years of qualified practice ranged from 1.5 to 33 years. 5 of the midwives worked in London, 3 in south east England, 1 in east England and 1 in the Midlands. Participants were invited to choose their own pseudonym in order to protect their identity. These are used throughout the report.

The 10 midwives in the sample worked in the following roles and band levels:

Name	Position	Band
Alice	Clinical Lead Midwife - Labour ward	7
Nell	(Free Standing) Birth Centre Midwife	6
Daniella	Community Midwife	7
Flo	Associate Director/Head of Midwifery	8
Polly	Consultant Midwife	8
Geri	Community Midwife Team Leader	7
Elizabeth	Midwife - Antenatal clinic	6
Iona	Community Midwife & Birth Reflections Midwife	6
Jane	Supervisor of Midwives - Labour ward	6
Claudia	Midwife - Rotational	6

Our findings

The value of dignity

Participants discussed the degree to which women's dignity during their birth experience was upheld and whether it had a lasting impact on their emotional well being and entry into motherhood. They said that

violations of dignity had the potential to cause trauma and remain with women for the rest of their lives. Bad birth experiences could make women distrustful of NHS maternity care in future pregnancies.

'Birth is your gateway to motherhood and if you feel like you've failed at the very first step ... it's going to make it so much harder because you know it's a massive part of how you perceive yourself as a woman.' Daniella

Defining dignity in maternity services

The interviewer asked participants what they understood by the term 'dignity in childbirth'. Midwives varied in the ease and depth with which they could speak about dignity and what it meant for their practice.

They were asked where they thought their conceptions sprang from. Responses centred on their understanding of dignity as something that they 'just had', based on their own internal 'moral compasses' rather than being something they had learnt through formal teaching. When outlining how their conceptions translated into practice, they said that they asked themselves the question: 'is this how I would want my sister/friend to be treated?.'

A dual concept

The midwives' definitions of dignity comprised two elements – bodily dignity and a second element, variously described as emotional or psychological dignity or 'personhood'. Participants described how it was critical for women to feel that they had been treated and cared for as a whole person. In order for women's dignity needs to be met, both of these elements of dignity needed to be protected and promoted by the people around them during their birth.

Bodily dignity was discussed by reference to protecting privacy through actions such as preventing women from being physically exposed and ensuring that doors were

closed. It was seen as the most obvious and relatively straightforward aspect of dignity to promote in practice. Protecting bodily dignity was believed to be well-addressed in maternity services generally. However, there was acknowledgement that if this was taken for granted privacy lapses could easily occur.

Midwives' understanding of personhood encompassed non-physical aspects of dignity. There was variation in the degree to which midwives reflected beyond the physical aspects and personhood was not always so quickly and easily discussed.

It was often difficult for the midwives to offer precise explanations of personhood and they dealt with it via discussion of the relationship between midwives and women. These reflections encompassed a range of aspects relating to how the woman's personhood was acknowledged. They included:

- Treating the woman as an autonomous individual.
- Treating the woman kindly.
- Protecting the woman and making her feel safe.
- Enabling women to make their own choices and exercise control.
- Communicating honestly with women.

'It's not just physical ... So it's more than just putting a sheet over her when someone's coming in the room or doing things, it's about building that rapport, getting her to tell you what she wants, anticipating it.' Claudia

'It is about empowerment and a woman feeling, I guess a lot of it is control and sort of ownership of what's happening to them and not just being told we're going to do this to you and we're going to do that to you' Student midwife

'I think power and dignity are pretty much synonymous.' Nell

Dignity is not...

Midwives gave examples of what they believed dignity in childbirth did not mean.

Dignity was not perceived to be about particular types of birth or birth outcomes but about the woman's perceptions of how she was treated and how she felt during the experience.

'She can have everything on her birth plan but if she didn't feel safe or that people really cared about her she'll still have had a bad birth experience ... if she had a midwife who just didn't seem to give a damn and she couldn't engage with her, it won't be a good birth experience, even if she got everything that was on the birth plan but it was done in quite a robotic way.' Geri

The midwife's role

Midwives are intermediaries between the woman and the healthcare institution through whom women experience the maternity care system. Participants discussed how advocating for women's was critical to this intermediary role.

Being a good advocate was based on respecting and working to implement and uphold women's preferences and choices. It was considered crucial for the midwife to be able to acknowledge her personal opinions and cognitively 'park' them so as to not override her ability to sincerely advocate for a woman. Participants felt that not all midwives possessed the ability to do this and as a result women could be let down.

Participants acknowledged a style of midwifery which was authoritative in nature where midwives were prone to 'bully' women into making the 'right' decisions.

'Some midwives ... perhaps see their role as being more about a sort of not quite surveillance but more of a sort of constant

risk assessor whereby you know things have got to be measured and ticked off.' Polly

Midwifery was viewed as being emotional work that involved midwives really 'being there' for a woman. This meant being able to tune in, engage and connect with women, quickly building rapport to establish a trusting relationship.

Participants described how an effective emotional connection involved treating each woman as an individual, with her own unique fears and desires, whilst ensuring that all women were treated equally compassionately and kindly. Midwives' emotional generosity was believed to be conducive to the woman having a positive birth experience overall and was critical to making women feel that their dignity was upheld. The quality of the emotional connection between the midwife and the woman was considered to have a potential impact on the level of pain relief required by a woman.

'When I'm looking after someone in labour it's all about can I make a connection with that woman and make her feel able to tell me what's really going on for her. And that would preserve her dignity better than anything else.' Nell

Communication

Honest, open communication was seen as central to treating women in a respectful way. By contrast withholding information from women was perceived as infantilising. Midwives believed that being truthful and frank with women was always the best option, including in situations when midwives were concerned or uncertain about what was happening. It was felt that women were able to cope with honest communication and could understand uncertainty.

'Honesty usually works, even in the most awful situations. It's much better to say "I

don't know" or "I'm a bit worried, so I'm going to call the doctor".' Nell

Participants discussed how communication could potentially become problematic between midwives and women and result in women feeling ostracised from midwives and the service generally. This was thought to occur particularly in cases where women refused recommended interventions such as induction of labour or monitoring in labour.

In these situations participants discussed how it was beneficial to good quality care to try to keep communication channels open by trying to understand what underpinned a woman's choice. A participant gave the example of a woman who had refused monitoring and had been labelled as awkward. A student midwife took the time to ask the woman why she did not want to be monitored, discovering that the woman found it painful. In this case it turned out the woman had a placental abruption.

Language barriers

'There's lots of challenges with looking after women who don't speak any English because they can't communicate their needs to you, they can't ask you what they want, tell you what they want, they're not getting the best care.' Jane

Working with women who spoke little or no English was seen as very challenging. Participants described how often, and particularly in labour, partners, family members or members of staff who happened to speak the woman's language would be used rather than professional interpreters. This was believed to have certain advantages such as being convenient, cost effective and kept conversation flowing better than a stranger interpreting.

However, there were also a number of disadvantages discussed in relation to the quality of the interpretation, reliability of

the information obtained from the interpreter and the appropriateness of placing this responsibility on partners/family members who could well have their own agenda. In particular midwives expressed concerns about gaining appropriate consent from women when using partners/family members as interpreters. Whilst it was acknowledged that partners were not supposed to be used as interpreters, midwives reported how it was often done in response to a lack of available interpretation services.

In cases when a professional interpreter was available this was also regarded as having drawbacks. Participants particularly questioned how appropriate it was for an unknown interpreter to be present during labour. In such cases it was seen as being a potential intrusion into the woman's privacy.

Telephone translation services, such as Language Line, were also discussed. They were experienced as being particularly difficult in emergency situations when accessing them might delay clinical actions being taken. In such situations midwives described how they could be left feeling quite disappointed in the quality of the care that it had been possible to provide.

It was felt that the more preparation and interpretation that could be done during antenatal care the better – for example professional interpreters outlining to women what could happen in labour. This was seen as going some way to lessen the difficulty of trying to convey large amounts of complex information during the woman's labour.

Presenting information

'It's about giving people the information they need to make realistic choices and not pressuring, not manipulating them into making the choices that are administratively convenient for yourself.' Geri

Participants described how the manner in which women were given information and offered research evidence was central to how able they felt to make choices about their treatment. They discussed how information and research evidence was not always presented as effectively or as ethically as it could be.

It was felt that research evidence was sometimes presented in a biased way to manipulate women into making choices that were in keeping with recommendations and guidelines that would make life easier for the staff rather than being in the woman's best interests.

One form that coercion could take was women being repeatedly asked, by different members of staff, whether they were 'sure' they did not want something done to them that they had already declined. In such cases midwives felt that the repeated asking amounted to a form of harassment deployed to force women to adhere to standard practice.

Information and research evidence was thought to be communicated most effectively and ethically when information was tailored to the individual woman and presented in a clear objective manner with an emphasis being placed on the autonomy of the individual woman to make her own decision.

Gaining consent

There was a consensus across the midwives that maternity care practitioners practice had greatly improved in gaining consent (particularly for vaginal examinations) and that it was now rare to fail to obtain consent. However, midwives did recount incidents where women's consent had not been granted and there was discussion of further improvements that could be made in how consent was sought from women.

'I have seen the other extreme where there's been absolutely no mention of what's going to happen and women's bodies have been touched without any consent whatsoever and in two cases I've seen women being held down to have interventions performed on them.' Daniella

Participants discussed how a culture of expected compliance permeated through the maternity care system which led to assumptions that women would just go along with routine care plans. This was visible in the language used to present examinations and interventions as simply being routine parts of normal care and failing to give any indication that women could decide to opt out of them. Induction of labour was frequently cited as an example of this:

'Often you see the word offer, induction was offered, something was offered, but it's not offered really, I mean if there's an offer there's an assumption that someone has an option to say "ooh, thank you very much but no I won't thanks", whereas actually that's not really what's meant at all.' Polly

Women who were not compliant and questioned or refused recommended interventions generated gossip amongst maternity care providers and were prone to be labelled as awkward or difficult.

'Women are made to feel so terrible if they don't conform, and they're talked about within the staff room, you know "I can't believe she hasn't done that" or "I can't believe she has done this". If you don't conform you are in a way stereotyped into being a bad woman.' Student midwife

Simple language was seen as crucial to consent gaining for clinical treatment. For example asking permission to perform vaginal examinations in an abstract way, saying things such as 'examine you down below' was regarded as too vague and potentially open to misinterpretation.

In contrast, being direct and succinct was considered a better way of enabling women to understand exactly what they were being asked to consent to. For example, saying: *'I need to put my fingers inside your vagina. Are you happy for me to do that?'*

Inequality in care

Women were not perceived to have uniform chances of receiving the same standard of dignified care. Women considered high risk, those with special needs, with lower awareness of their rights and women who did not have English as a first language were likely to receive poorer quality care.

Women from lower socio-economic classes or women with involvement from social work services were perceived to receive a different quality of care to women from higher socio-economic classes. There was a feeling that these women were prone to have lower awareness of what services were available to them and their rights and choices about the maternity care to which they were entitled.

'Every woman is told about it [home birth] but you know it's like breastfeeding in Liverpool. It's not for the likes of us, it's alright for them middle class Boden wearing women but you know we don't do it.' Geri

One group of women who midwives particularly highlighted as being at risk of receiving poorer quality treatment were women with a high Body Mass Index (BMI). These women were thought to be at risk of receiving a poorer quality of care due a perceived attitude of a lack of respect which translated into care lacking in compassion and kindness.

Midwives discussed how poor attitudes to women with high BMIs could be evidenced in how they were spoken about by staff with comments made such as *'how could she let herself get into that state?'* Midwives discussed witnessing poor attitudes lead to

care that lacked compassion, such as treating women roughly when using equipment.

A two-tier system: low and high risk women

'It's quite a scary area, the high-risk labour ward end there's a need to exert control ... And it can become quite an oppressive culture in some places.' Geri

Our research revealed a two-tier care system in which a woman's risk factor was seen to have a powerful impact on the care she might expect to receive. Low risk women were perceived to have a better chance of receiving care that upheld and supported their dignity compared to those seen to be high risk.

A woman's risk status had a specific impact on where she was *'allowed'* to give birth: low risk women were allowed access into birth centres and home birth services whereas high risk women were not. Midwives described how high risk women's self esteem could be seriously undermined by being told that they were not permitted to birth in certain environments. In these situations the midwife was seen as occupying a critical role in reassuring women that they would still receive good quality care.

High risk women who questioned their lack of choice could set off a process of coercive and disrespectful communication from maternity staff.

Participants described how the attitude of the midwife and how she perceived risk were key to determining the nature of care that high risk women received. Midwives who worked in a thoughtful, flexible way that prioritised the woman's needs above her risk status were perceived to offer a good quality of care, but not all midwives were believed to work in this way.

'Once someone's labelled, that's it and not really a sort of thinking what is the meaning of this risk?' Polly

Participants provided many examples of how care could be delivered in ways that treated high risk women with dignity by respecting individual women's preferences.

The physical environment

Birth centres and women's own homes were perceived to be environments more conducive to promoting positive birth experiences because women had more control over their care and surroundings. In contrast labour wards were described as being less conducive places, where there were more interruptions for birthing women, such as consultant ward rounds.

The actual appearance of the physical environment was thought to be of limited and superficial importance. The quality of the care provided and how safe the woman felt were considered more important. In particular the relationship, and emotional connection with the midwife, was stressed by participants as being key:

'So as much as you can dim lights and play music I think it comes down to your persona the way you are with the woman. You make that difference very, very quickly for them.' Elizabeth

Postnatal wards

Midwives reported that women on postnatal wards experienced poor quality of care and frequent violations of their dignity. Postnatal wards were not considered to be environments conducive to promoting recovery from labour or breastfeeding. Midwives found postnatal wards challenging environments in which to maintain dignity and privacy for women due to the nature of their design, including thin curtains and the close proximity of beds. Midwives discussed how they would employ strategies to try and

maintain dignity such as helping women to the bathroom and having conversations en route rather than in the bay where other women could hear.

The impact of low staffing levels

Various institutional factors were identified as posing particular challenges to midwives' ability to protect women's dignity.

Low staffing levels was frequently discussed by participants, who said that caring for more than one woman had a serious detrimental impact on their ability to protect women's dignity. Participants described how more often than not they would have to '*juggle*' more than one woman in labour. In those situations, it was very difficult to treat women with compassion. Midwives reported that on occasions they were '*not really present*' in the room with the woman as a result of the pressure. Less experienced midwives particularly struggled with the challenge.

'One way of dealing with the chronic exhaustion, disappointment and anxiety that that creates in the staff is a distancing. As a self-protective mechanism is to get less involved. Say it's just a job. It's just a job. Because otherwise you know they get burnt out.' Geri

The community midwives in the sample stressed how rewarding it was to be able to offer continuity of care to women and how working in this way enhanced their ability to build trusting relationships with women.

In contrast, the midwives who worked in hospital settings described employing specific strategies to build a trusting relationship with more than one woman at a time. For example, a labour ward midwife described how on her first meeting with a woman on the labour ward she would make the first half an hour '*about nothing but what's going on in that room*' .

There was a perception that there was a certain type of midwife who was more suited to working on busy labour wards. These midwives were referred to as '*high octane trauma midwives*' who had managed to cut themselves off from the emotional part of the role, getting by on the '*high*' of working in a high stress environment. Such midwives were perceived to be very technically competent, especially in terms of keeping women physically safe in emergency situations, but not necessarily able to cope with providing emotional support.

Guidelines and protocols

The use of guidelines and protocols was discussed as potentially diminishing women's dignity. Midwives described the pressure they were under to demonstrate their compliance with guidelines.

'What's happened in the last few years, in the struggle to improve standards of care we have protocols so it's all about compliance and compliance gets more heavy-handed every year so the midwives are under a great deal of pressure to demonstrate their compliance with all the protocols.' Geri

They gave examples of different approaches to using guidelines. One approach was the use of guidelines as absolute rules, as a '*Bible*' with midwives quickly referring matters up to doctors. This approach was perceived to be deployed by more vulnerable midwives, including those who were newly qualified and midwives whose practice had previously been under investigation.

'You're actually an autonomous practitioner as a midwife and I think some midwives forget that. So I think staff are driven by time constraints and guidelines and they forget to use their heads sometimes.' Alice

Fear of litigation

Participants perceived fear of litigation to play a role in how midwives were able to protect dignity. This was thought to be especially true for high risk women's care.

A culture of blame for bad outcomes was proposed as a major factor leading to defensive practice. In order to protect themselves midwives felt compelled to produce very thorough documentation at the expense of providing high quality midwifery care.

Participants also discussed how fear of litigation could lead to blunt and emotive warnings from practitioners to women, such as women being told that they or their baby could die. Fear of litigation was perceived to impact on how much choice women could be offered.

'People sometimes think well it's better to play safe than it is to offer choices that you might not want that woman to have.' Student midwife

The degree to which midwives perceived the extent of their responsibility for birth outcomes and whether they accepted that things '*just happen*' was identified as a factor that affected defensive practice.

Managers and supervisors

The importance that management and leadership placed on dignified treatment was seen as having an important impact on the ethos of the ward. In discussing how dignity was promoted examples were given of leaders picking up on environmental measures, such as shutting doors and ensuring clean gowns were available to women. Participants found it more difficult to describe non-physical ways in which leadership ensured that women were being treated with dignity.

Supervisors of midwives were seen as a potential resource for guaranteeing women's dignity. There were mixed views about how effective supervisors could be at supporting midwives given the inherent tension between providing support to midwives whilst also acting in a '*policing*' role. In relation to their clinical role, such as formulating care plans for women, supervisors were considered very helpful and were even described by one midwife as being the '*saviours of midwifery*'.

Training

The training that midwives received regarding upholding and promoting dignity in maternity services was not believed to be as good as it could be. Training usually emphasised ensuring bodily dignity but insufficient time was devoted to the personhood elements of dignity. Training focused on rare emergency situations rather than the everyday interpersonal skills required to be a midwife.

Midwives suggested that more training time needed to be devoted to supporting the emotional aspects of providing dignified and compassionate care. It was said that it should not be taken for granted that these skills were inherent in midwives.

Conclusions

The midwives in this study self-selected and can be taken to have had an existing interest in the issue of dignity in childbirth. Nonetheless, the research shows that midwives in a variety of positions and with different levels of experience generally have a good understanding of the meaning of dignity for birthing women. They are also highly aware of the challenges that midwives face in ensuring that women are treated with dignity and respect.

A variety of suggestions for improving standards of dignity in maternity care

emerged from the interviews. These included:

- structural changes in the NHS approach to midwifery care towards continuity of carer;
- better training on dignity and personhood;
- explicit dignity guarantees and dignity champions on maternity wards;
- better channels for feedback from women about their experiences of dignity in childbirth;
- allocated time for midwives to reflect on their practice;
- formalised emotional support for midwives.

The research has shown that there is a need for further investigation into the structures and innovations that could support midwives to promote and protect women's dignity.

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