

BPAS submission to the Health and Social Care Select Committee inquiry

Safety of maternity services in England

The British Pregnancy Advisory Service, BPAS, is a charity which sees almost 100,000 women a year for reproductive healthcare services including pregnancy counselling, abortion care, miscarriage management and contraception at clinics across the UK, and in 2021 BPAS will launch a not-for-profit fertility service. It supports and advocates for reproductive choice. BPAS also runs the Centre for Reproductive Research and Communication, which seeks to develop and deliver a research agenda that furthers women's access to evidence-based reproductive healthcare, driven by an understanding of women's perspectives and needs. The Centre is home to the WRISK project, a collaboration between BPAS and the School of Social Sciences at Cardiff University. Working with stakeholders from a wide range of disciplines, the project centres women's experiences to understand and improve the way that pregnancy-related risk is communicated in the media, public discourse, and healthcare settings. The project is funded by the Wellcome Trust.

Introduction

Women and their babies deserve world-class, safe maternity care. The relatively high rate of stillbirth in this country remains a key concern, and must be addressed. It is vital that we do this in a way that accepts risk can never be completely eliminated from any area of healthcare, and that the drive to improve safety and reduce adverse outcomes does not come at the expense of women's agency and right to make their own choices in pregnancy and birth - indeed the former cannot be achieved without the latter. Women must be trusted to make decisions, based on the best available evidence, about what is right for them and their pregnancies. Equally we are concerned about a culture in which women's themselves are increasingly held accountable for negative outcomes because of their BMI or "failure" to prepare for pregnancy, and it is crucial that in our efforts to improve maternity safety we ensure risks are properly contextualised when they are communicated to women, the wider social determinants of health appreciated, and women supported – not stigmatised – as they engage with maternity services.

This submission will focus on addressing the advice, guidance, and practice on the choices available to pregnant women and how women experience this, using evidence gathered through the WRISK Project. We conducted a survey of over 7000 participants and subsequently interviewed 33 women and 1 non-binary person in depth about advice, support, and decision-making in pregnancy. Our interview participants represent people from a wide range of socio-economic backgrounds. Approximately 30% of the interview participants

identified as BAME; 12% of the participants were Black (African & Caribbean); 30% of the participants were in receipt of a means-tested State benefit; and participants represented communities from across the whole of the United Kingdom.

Key points:

- Women often felt their choices in childbirth were restricted, whether they were “low” or “high” risk
- Women felt information and advice was not always conveyed in a balanced way, but delivered in such a way to achieve what care providers thought was the desirable decision
- Women living with obesity reported poor experiences, and feeling “at fault” for entering pregnancy with a higher BMI that raised risks of more adverse outcomes like stillbirth
- The significant emphasis on smoking and alcohol during antenatal appointments, even when women did not feel this was relevant to them, meant that other pertinent issues – such as managing mental health – were not well addressed.
- Younger mothers felt that their wishes were not respected because of their age.

1. Birth choices

Some women we spoke to felt their choices were limited by what category of “risk” they fell into, with lower risk women struggling to attain a more medicalised experience if that was their preference, and higher risk women feeling that a medicalised pathway had been determined for them from the outset. Planned caesarean birth was often not offered to women who requested it, and some women felt information was provided in a particular way to ensure a particular outcome, in keeping with hospital policy or targets.

“The current approach is strongly biased towards hospital based natural birth. Any deviation, such as maternal request section or home birth is discouraged. I was actively lied to about the risks inherent in VBAC [Vaginal Birth After Caesarean] in order to force me to undergo VBAC. The single most stressful thing during that pregnancy was that. Women’s choice of birth method must be respected. It’s disgraceful that women are not informed about the risks of VB, that antenatal classes gloss over the risks of instrumental delivery. Advice about food etc is evidence based - why not advice about birth? If a woman wants a

home birth and there are no absolute contraindications she should get one. Ditto sections. NICE itself has costed them as being only 80 ish quid more expensive when injury repair is taken into account.”

“I was keen for elective c-section but was really really pushed [to accept] a VBAC it all went very wrong and ended in a cat 1 section, uterine rupture and resuscitated baby. I wanted a section and was heavily pushed and made to feel guilty about the risks of lung development etc and baby being poorly when born for choosing an elective.”

Yet women living with obesity, who now account for more than one in five pregnant women, could find it much harder to attain a midwife-led vaginal delivery, if that was what they wanted.

“[I was] overweight. From the start I felt like a lesser person, with all the additional checks etc. Whilst I know these things are needed, being told you are ‘big risk’ constantly is very disheartening. Also not being allowed in birthing unit etc [makes you feel] very excluded.”

The stigmatisation of women with obesity, some of whom feel they have “failed” from the start of their pregnancy journey, may mean women are reluctant to seek help when they need it:

“I was completely shamed for being fat. I had wanted a baby for so long but left the booking appointment hoping for a miscarriage as I felt so irresponsible for getting pregnant; that I had unduly put my baby at massive, unnecessary risk. At the 36 week growth scan, the consultant said I could not have the birth I wanted at my weight. I was told I would need interventions. I was not treated as an individual who had had a completely uncomplicated pregnancy (and who later gave birth to a perfectly healthy baby). I was so unbelievably distressed after that appointment that I believe it led me to go into early labour just a few days later. And I was too frightened to go to hospital for fear of how I would be treated.”

As noted by AIMS, “the decision whether or not to have a home birth rests with the mother... Midwives, GPs, or obstetricians are there to advise... Even if a doctor has defined your pregnancy as 'high risk' you are still entitled to midwifery care and to have your baby at home if you wish.”¹

Some women we spoke to who were living with obesity spoke of conflict when they tried to advocate for a home birth, or a water birth in hospital. It is unclear if these restrictions were based on hospital policy. The organisation Big Birtha’s analysis of hospital trust policies found that there are hospital policies which explicitly state restrictions on home births and water births for women with a higher BMI.

¹ <https://www.aims.org.uk/information/item/choosing-place-of-birth#post-heading-5>

One woman living with obesity actively sought (and achieved) a home birth as a result of her negative antenatal experiences in hospital, although she felt additional and unnecessary barriers were put in her way to seek to dissuade her.

“I’d decided that I was going to go ahead and have a home birth. I obviously knew that wasn’t advised. They sent me to the head of midwives.... She said that I would need to purchase a hoist for my home. If I was to become incapacitated during labour or birth, I would be a manual handling risk for the midwives who were with me.... “If you die during labour, we need to consider you as an object.”...She said that I would need to purchase a hoist for my home... She said, “But you would need to take the doors off, probably, to get a bariatric stretcher through your door.” Towards the end of the pregnancy, when she came to my home, I said, “Look, you were talking about this, do you actually want me to do that?” She said, “No.”... I don’t feel it was bullying but I do feel it was coercive. I don’t know where that coercion came from. It may be that she was required to say that as hospital policy.”

When women were refused birthing choices, the reasons for this were not necessarily well explained, nor women supported in understanding the risks and benefits to make their own choices.

“I like the idea of a water birth, because I think water sounds calming, relaxing and chilling. But unfortunately, they’ve told me I won’t be able to have one with my gestational diabetes. I’ve tried to push it in- Not forcefully, but I’ve just been like, “I don’t see what the problem is.” As far as I’m concerned, everyone seems to think that the bloods that I’ve been issuing and my results that I’ve been issuing in regards to my blood levels, everyone seems to think they’re fine.... there’s no-one really that has actually said, “Do you know what? We will try and do that for you.” There has not been that sort of, “We’ll work with you on that, because it’s what you want.” That’s where I’ve- That’s the only sad part where I’ve come to struggle with it a little. Because I was just like- That’s the only thing I ever actually wanted from this pregnancy, was just a water birth.”

2. Advice and guidance on induction

Induction is offered to all women who do not go into labour naturally by 42 weeks because of the raised risk of stillbirth thereafter. Women over 40 may also be offered induction around their due date to reduce the risk.

While NICE recommends the reasons for, risks, benefits and alternatives to induction, this was not always conveyed in a way that contextualised the nature of the risk.

“I felt that some statistics were given to me in a misleading way. Such as because of my age there is a 50% risk of still birth if I go over my due date. Whereas if it was re-worded it sounds very different. I felt statistics were used to make me go down a very medical sort of childbirth”

“I felt unduly pressured into having an induction because of the risk of stillbirth as I was high risk. I have since come to learn that the risk of stillbirth was only 2% and I would have liked someone to tell me that in advance rather than pushing the “better be safe than sorry”. No one told me I could say no to being induced and I now have to live with this for the rest of my life.”

Induction can be more painful than spontaneous labour, and pain relief options should also be discussed.

“I was induced and the information on what to expect was not provided, I was not advised to seek pain relief (despite the NICE guidelines recommending it) and as a result I spent nearly three years feeling like I’d failed.”

And while some women felt pressured to accept induction, others were unable to obtain the intervention they wanted.

“The midwife was pushing hard to continue my pregnancy till 42 weeks. I could tell my baby was going to be big from a growth scan when baby had a huge surge in growth. I should have been listened to when I said I wanted to be induced at 40 weeks. I ended up going 42+5days with a failed induction and then an emergency c section, where it was noted I wouldn't have been able to push my baby out with serious complications. The placenta had started to die and baby had pooped inside unknown for how long. If I was listened to the whole experience I believe would have been less stressful. Women know their own bodies.”

3. Interventions performed during labour without consent.

Guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) states that, with the exception of an unanticipated emergency or in cases where the patient lacks capacity, medical professionals should seek a patient’s consent before performing any procedure.² The guidance also states that prior to seeking a woman’s consent for an intervention, the practitioner must ensure that the patient is fully informed, understands the likely consequences and the risks of receiving no treatment, as well as any reasonable alternative treatments, and that women should be encouraged to express their views on procedures so that their carers are aware of the choices made by the women and act accordingly. NICE guidance also states that medical professionals should “ensure that the woman is in control of and involved in what is happening to her.”³

² <https://www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga6.pdf>

³ <https://www.nice.org.uk/guidance/cg190/chapter/Recommendations>

Evidence from the WRISK Project interviews suggests that consent is not always being obtained in line with guidance from RCOG and NICE. Some women reported declining specific interventions, which were then performed regardless.

“I had declined certain interventions during labour, then they were done anyway. I requested my notes from that. It was like, “At 12:00 o’clock, patient declined to have a drip put in and then said we will re-discuss this in one hour.” Then, at 12:15, it said, “Cannula inserted.” Fifteen minutes later, the intervention had been performed. I knew that I hadn’t changed my mind in those 15 minutes.”

4. Antenatal appointments

While the booking appointment may be up to an hour long, subsequent appointments are 10-15 minutes long. Research suggest midwives find they are expected to deliver a “wall of information” on public health issues during pregnancy and express concern about a “one size fits all” approach:

“We use a computer program where you have to achieve all your “ticks” to be compliant. Everytime a new public health initiative appears so does another box, yet it still has to be done in 15 minutes....It should be possible to make it tailored to the individual rather than ensuring tick box compliance.”⁴

Women we surveyed reported receiving significant information about smoking and drinking, even when it was not relevant to them, and to the exclusion of other issues that mattered to them or that in retrospect they would have liked more support and advice on.

“Although I didn’t smoke or drink I received much better information on this than anything else. I didn’t receive any information on maintaining good mental health during pregnancy and I feel this contributed to me developing PND”

“It is very important to include information and advice on urinary and faecal incontinence as well as looking after the pelvic floor before, during and after pregnancy. Something so important with a high long-term impact and yet not mentioned nor given the importance that it deserves. It contributes to its normalisation, to remain silent and to get on with it.”

The use of carbon monoxide testing to objectively test a woman’s smoking status is seen as a key component of measures to reduce the number of preterm and stillborn babies. However the efficacy of this as a measure to help women stop smoking is not known, and the benefits need to be set against the fact that women may perceive it as intrusive and as surveillance of

⁴ Sanders J, Hunter B, Warren L. A wall of information? Exploring the public health component of maternity care in England. *Midwifery*. 2016;34:253-260. doi:10.1016/j.midw.2015.10.013

their bodies. This woman described how she felt it undermined her relationship with her midwife by automatically introducing an element of distrust.

“I always thought it’s bizarre asking someone for their subjective answer and then you are almost like, “Right, well that means absolutely nothing because we need to do a test of the carbon monoxide in your blood anyway.” I think that’s rubbish, really, because the relationship between midwife and mother is really, really important. I think we should be making sure that’s as strong as possible throughout pregnancy....I think [testing] strengthens that power imbalance between clinician and patient”

5. Younger mothers felt that they were unable to make choices

A Department of Health paper from 2009 states that young parents are less likely to engage with clinical care, due to a range of interlocking factors, including perceived negative attitudes among maternity professionals.⁵ A Swedish study found that young women aged 15–20 years recalled being more afraid, and experiencing more pain and lack of control compared to women in older age groups.⁶

Three of the younger mothers we interviewed spoke about the directive advice they received from healthcare professionals and a lack of respect for their choices. All three women attributed this to their younger age.

“I think she [the midwife] did make quite a few comments about how young I was... When it came time to push, I told her I wanted to be on all fours, and she started shouting at me telling me that’s not how I was doing it and I was to get up on my knees and hold on to the back of the bed. So that’s kind of how that happened.”

One of the young women said that when she was pregnant at 18, her wishes about her treatment and care were not respected, in contrast to when she was pregnant at 21:

“I found that a lot of healthcare professionals, they talk down to you a bit, because you clearly mustn’t know anything. You can’t research anything. She’s only 18. They don’t respect your wishes. Like things that you might’ve researched, they try and change your mind on. Whereas now I’m 21, and I’ve gone out there and I’ve researched everything, and I’m going back to make my own decisions, they’re a lot more, “Oh yes, that’s fine,” whereas three years ago, they were not fine with that, and I felt like I had to fight for a lot of things that I wanted in my pregnancy.”

⁵ https://dera.ioe.ac.uk/10606/7/DCSF-00673-2009_Redacted.pdf

⁶ <https://obgyn.onlinelibrary.wiley.com/doi/10.1080/00016340701657209>

Conclusion

Maternity services are stretched and constantly under pressure to do more, creating challenges for healthcare professionals who want to provide the best possible, individualised care to every woman who needs them. There should be no contradiction between striving to create the safest maternity culture with respecting the rights and autonomy of pregnant women; however it is clear that this is not always the case.

Pregnancy and birth will never be risk free and women should be supported to understand the risks and benefits of procedures and pathways, with information conveyed in a way that contextualises risk and uncertainty and recognises that women may have different approaches to risk and risk management, which will influence the choices they make. Ultimately we must ensure women are able to make their own decisions around pregnancy, labour and birth and that potential interventions are well explained in the antenatal period so that women are prepared and better able to provide informed consent when necessary.

The considerable public health focus on alcohol consumption in pregnancy and current calls to increase midwives' monitoring of pregnant women's drinking during antenatal appointments, despite the fact that booking data shows less than 3% of women are drinking more than a unit per week by booking, must be balanced against women's need for a breadth of information and focus on areas relevant to them to ensure the best possible outcomes for themselves and their babies.

