

Please imagine, for a moment, that you are on the labour ward caring for Annie, who is in labour with her first baby. Let's say that Annie went into spontaneous labour at 41 weeks, has had a happy and unproblematic pregnancy and there's not a risk factor in sight. She is using entonox and you have just carried out a vaginal examination with her blessing and found her cervix to be completely effaced and 8cm dilated. Although you feel that she is making reasonable progress for a first time mother, Annie is despondent that she isn't further along and tells you that she wants an epidural. What do you do?

OK, so most midwives would want to talk Annie through the decision; discuss whether she expressed preferences on a birth plan, outline the pros and cons, but let's assume that she had no preconceived ideas and doesn't feel like having much of a conversation, because the question that I am really pondering is this:

Is it more woman-centred to (a) nip straight out and phone the anaesthetist, or (b) use all your skills of encouragement and a bit of distraction to help Annie through the next hour or so and aim for a normal birth without the epidural?

Can we justify distractive practice?

I've been talking to midwives a lot about this question lately, and there are no easy answers. Many midwives are concerned about rising intervention rates and are doing their utmost to promote normal birth. Some of them are understandably attracted to the "of course we'll get you an epidural; we just have to do these 37 things first" approach. In taking their time preparing for the epidural (with the obligatory loo visit, blood pressure, abdominal examination and updating of notes, while offering increased encouragement and support) they hope that, by the time all of this is finished, either the head will be visible, the urge to push will be felt or Annie's desire for the epidural will have passed. And, yes, it can be very gratifying when this kind of distractive practice leads to a woman being ecstatic that she didn't have the epidural after all and 'did it herself'; perhaps especially in those situations where midwives know that the constraints of the system mean that the anaesthetist is going to take a while to get there and that the epidural may end up being sited at a time which is even more likely to stall Annie's labour.

Yet there are other midwives who feel that this is inappropriate and that option (a) is more woman-centred, not least because women are, unfortunately, not strangers to persuasion, manipulation and even coercion from maternity service providers. However happy some women might ultimately be when they realise that they have coped without the epidural, option (b) is about manipulating the situation in order to aim for an outcome that we feel is best for the woman, rather than responding to the woman's voiced request. Worse, 'Annie' might never forget the way her

midwife ignored her appeal and stalled for time rather than meeting her voiced request for pain relief.

Multiple Kinds of Risk

Some of the recent discussion around the area of choice has focused on the issues that arise where women plan ahead in making choices which they then struggle to be 'allowed' to implement (e.g. Kirkham 2004). Women who decide to decline tests and treatments that are perceived by professionals to be necessary are sometimes persuaded to change their minds by those professionals. In discussing how this impacts upon women, Nadine Edwards (2004) shows that

"Decreasing autonomy risks decreasing women's sense of self-worth, self-trust, self-esteem and confidence" (20).

Does distractive practice - which may, in this scenario, be done with the intention of helping a woman avoid intervention that a midwife feels is unnecessary and that might increase the risk of further intervention - carry the same risks to a woman's sense of self? One of the difficulties with this kind of scenario is the question of whether a woman in labour, who may be experiencing great discomfort, might feel differently later on. This could be a useful conversation to have with Annie, if only we weren't otherwise working to help her quieten the rational, thinking part of her brain in order to keep her labour moving along, which means making an effort to avoid the kind of lengthy, complex discussions which can pose a risk to the ongoing progression of labour. The risks, it seems, are there at every turn.

I apologise for ending with more questions, but the complex reality of the modern way of birth means that simple answers can rarely be found at the bottom of the page. Can there be such a thing as woman-centred distraction? Or woman-centred timewasting? Or are these concepts contradictions in terms? Does the end, in this kind of situation, ever justify the means, or are these means fundamentally incompatible with the notion of woman-centred care?

Kirkham, Mavis (Ed) (2004) *Informed Choice in Maternity Care*. Palgrave Macmillan, Basingstoke.

Edwards, Nadine P (2004) *Why Can't Women Just Say No? And does it really matter?* Chapter 1 in Kirkham (2004) *Op cit*. pp 1-29.