Trusting the Experts, Mistrusting Birth: Women’s Relationships with Private Obstetricians
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Abstract

Research shows that women from high-socio-economic backgrounds with private obstetric care are the group most likely to experience medical intervention in birth, despite being among the healthiest women in society. This anomaly is often understood as a ‘choice’ issue by the popular media and among the obstetric profession, while social researchers point to the ways in which women are entrenched in and constrained by the hegemonic biomedical model of birth. However scant attention has been given to women’s individual relationships of trust and dependency with their doctors. Drawing from preliminary interviews with women using private obstetric care, this paper argues that that women in the study enter into a relationship of trust with their obstetrician which is based both on their class positioning and their belief in medical birth and further, that women’s confidence and trust in their own ability to birth without medical expertise is subtly eroded in the medical encounter as well as through cultural fears surrounding birth.

Key words: private obstetrics, trust, childbirth, pregnancy, class, women, medical power

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Introduction

Despite years of critique and the advocacy of feminist, consumer and midwifery groups, epidemiological research shows that in Australia and elsewhere, women in high socio-economic brackets, with private obstetric care, are more likely to experience medical intervention in childbirth than any other group (King 2000; Ford, Nassar et al. 2002; Baker 2005; Laws, Abeywardana et al. 2007; O’Leary, de Klerk et al. 2007). This is somewhat anomalous given that this particular group of women tend to be society’s healthiest and therefore the least likely to actually require medical intervention (Baker 2005:32). The discrepancy is often put down to women’s ‘choice’— women in higher socio-economic brackets are said to be more likely to exercise choice in childbirth than other women. It is a discourse apparent in both popular media and among obstetricians themselves (Kiran and Jayawickrama 2002; Simpson 2004; Handfield, Turnbull et al. 2006; Bettes, Coleman et al. 2007; Weaver, Statham et al. 2007). Recent qualitative research also suggests women are more likely to request medical intervention than in previous decades (Green and Baston 2007).

The rhetoric of choice in childbirth has become omnipresent both in Australia and internationally. However, many critics point to the complexity of this neo-liberal notion of autonomous choice, highlighting the social, institutional and discursive constraints on agency (Wagner 2000; Anderson 2004; Weeks 2005; Bryant, Porter et al. 2007). For example, while women are viewed as self-governing and independent, agency is often organised around the set of choices made available to women by obstetricians and mediated through medical knowledge and the workings of neo-
liberalism (Bryant, Porter et al. 2007: 1197). The cultural ambivalence and fear surrounding normal birth in contemporary culture (Reiger and Dempsey 2006) further complicates the notion of free ‘choice’ in relation to childbirth, although little attention has been focused on the ways women negotiate these cultural discourses within individual relationships with their obstetricians. Moreover, while there has been some analysis of the role of trust in the healthcare encounter (Gilson 2003), scant consideration has been given to the relationships of trust in maternity care.

This paper draws on my doctoral research examining the social construction of birth knowledge in textual sources and by pregnant women. The data presented is a work in progress drawn from preliminary interviews with 11 women, which aims to discover ways in which women gain knowledge and understanding about childbirth and how that knowledge becomes embodied in their birth experiences. More specifically, the project seeks to re-examine the dissonance between the feminist critique of childbirth “and the beliefs, desires, reactions, and behaviours of women”, as identified in Davis-Floyd’s American research over a decade ago (1992). As Kitzinger et al put it: “Why do women go along with this stuff”? “This stuff” refers to interventions and practices such as electronic foetal monitoring; the induction of labour; epidural and surgical births; all of which despite lack of evidence regarding their effectiveness, or their ability to produce better outcomes for mothers and babies, continue to be routinely used in most hospital births (Enkin 2006; Kitzinger, Green et al. 2006; Wagner 2006).

Previous analyses of middle-class women’s birth experiences conclude that women who are entrenched in the powerful and hegemonic medical model of birth seek to control the birth experience using medical technology in apparently empowering ways (Sargent and Stark 1989; Davis-Floyd 1992; Lazarus 1997; Zadoroznyj 1999,
In contrast, my research found that the women interviewed did not believe that birth was something that could be controlled. Whether they were pregnant for the first time or expecting their second or third child, they believed birth was unpredictable, that normal or ‘natural’ birth was an ideal and that interventions were often necessary. This paper has a twofold argument; that women participating in this study enter into a relationship of trust with their obstetrician based both on their class positioning and their belief in the biomedical model of birth and that their confidence and trust in their own ability to birth without medical expertise is subtly eroded in the medical encounter as well as through cultural fears surrounding birth.

Methodology

Ethics approval was granted from La Trobe University to recruit professional women aged over 30 with private obstetric care. These women were specifically targeted for the reasons described above. Women were recruited through leaflets distributed at obstetrician’s offices and through various Internet pregnancy and birth forums. Semi-structured interviews were conducted with 11 women aged between 30 and 37 with an average age of 30.5. All were either married or partnered in heterosexual relationships. All except one were in an income bracket exceeding $AD100K per year and all had bachelor level degrees or higher. Three women were born outside Australia; in Denmark, America and Hong Kong, and the remaining were Australian born with Anglo-Celtic backgrounds. Women were between 16 and 32 weeks pregnant. Four were expecting their first child, five were pregnant with their second child, and two were expecting their third child. Nine women were interviewed face to face in their homes and two via telephone. General questions were asked about the sources of information about birth consulted during the pregnancy, their expectations
of childbirth, their relationship with their obstetrician, decision-making and choice processes, general attitudes and beliefs about childbirth and the level awareness of contemporary media debates around choice in childbirth. Additional information/data was gathered via a private Blog set up so that the women could journal aspects of their pregnancy and journey to childbirth and communicate among each other. All interviews were transcribed verbatim and then coded for key themes with the aid of QSR Nvivo software. Pseudonyms are used throughout the paper wherever names are given.

Reasons for choosing private obstetric care

Evidence-based medical researchers, governing health bodies and advocacy groups state that care for women with normal pregnancies is best overseen by midwives in low-tech settings (Goer 1995; WHO 1996; Enkin 2000). Yet in Australia some 30% of women, who tend to be older and in higher socio-economic groups, use private obstetric care (Laws, Abeywardana et al. 2007). This is a higher figure than other countries with similar health care systems (Mander 2007:61). The majority of women interviewed say they chose private obstetric care because they already had private health insurance and thought they “might as well use it”. As Zadoroznyj’s (1999, 2001) research shows, women take on a role as active consumers, “shopping around” for the right obstetrician. This was the case with the women I interviewed. However, the interviews also suggest that the reasons for choosing private obstetric care were more complex than simply a matter of pragmatics. In particular the influence of spouses, family and friends and cultural expectations of what one ‘should’ do, were factors in women’s reasoning for choosing this model of care.
I think it’s just that thing about being ‘just what you do’ among my circle of friends. Sandra, 3rd pregnancy.

My husband was quite ‘private it is’ um, I don’t really know why… my older sister… used to say you know ‘make sure you go private, so I kind of remember that… yeah so that wasn’t really a big decision whether I was private or not. Brooke, first pregnancy.

I don’t think I once considered the public system, I’ve been in private health cover probably since the day I was born… my mum had a private obstetrician and had private health cover for all us girls and I think I just took over from that. Kim 2nd pregnancy.

Some women also positioned themselves in class terms as “being able to afford the best possible care”, differentiating themselves from women who face long waits, different caregivers, “less qualified staff” and, whom they presumed received poorer quality care in the public system. Other women implied that private obstetric care was the choice of “educated” women. While the importance of having one care-provider was something that most women reiterated, women’s social positioning came across as an integral reason for choosing the private model of care. Most women interviewed constructed themselves as particular kinds of women who would naturally use private obstetric care. For example, they asserted that they would never choose a home water birth, or a birth center with midwives because “I’m not that kind of person” or “that’s just not who I am”. This sort of positioning seems to suggest that using a private doctor is tied to the women’s identity as middle class, educated and privileged.

Trusting the Experts

The majority of women interviewed expressed sentiments that aligned with the hegemonic medical model of birth; thus while their positioning as middle-class was
important, underlying their prime reasons for choosing obstetric care were views that espoused childbirth as a medical event in which doctors are the trusted experts;

I liked the idea of having medical things around me; it gave me a psychological safety blanket. Sandra, third pregnancy.

I don’t see [birth] as a spiritual experience, no, um I see it as a medical event in your life…I don’t see it as ethereal or anything like that. Jenna, Second Pregnancy.

The ways in which pregnant women are entrenched in, and confined by the hegemonic medical framework of risk and pathology have been discussed extensively in previous analyses and it is thus not necessary to go over familiar ground here (Oakley 1980; Martin 1989; Sargent and Stark 1989; Davis-Floyd 1992; Jordan 1993; Lazarus 1997; Zadoroznyj 1999, 2001). Less analysed however, are the characteristics and dynamics of women’s individual relationship with their doctor (but see Oakley 1980; Zardoroznyi 1999, 2001). Women’s faith and immersion in the technocratic/medical model of birth forms the basis of their trust in obstetricians. All women interviewed reiterated, often more than once, that they trusted their obstetrician implicitly, not just in terms of their clinical expertise (although this was important too) but also as an individual person;

He’s someone who’s specialised and done 10 years of research and I’m figuring it out as I go a long so yeah. I’m big on subject matter experts and he knows more than me about these things, so I trust him. Louisa, first pregnancy.

There’s just something about his nature, that he’s the kind of person that you just hung on to what he said. Um, you just trusted him and I trusted him implicitly. Sandra, third pregnancy.
He’s very unobtrusive, he not in your face. So basically he’s there to look after you, answer questions, whenever I need him I can call him with any questions, he doesn’t worry about that, anytime of the night, he’ll give you a call back…He’s always there …he’s there just for you, to you know, guide you and stuff. Kim, second pregnancy.

Trust extended further than to a doctor’s expertise and personal qualities but also to their general professional motives. For example, although most women were aware of the criticisms aimed at the obstetric profession, particularly surrounding the epidemic of caesareans, many women claimed that their doctor “wasn’t like that” or that their doctor had a low intervention philosophy and wouldn’t intervene unless “necessary”. Gilson’s (2003) analysis of trust in healthcare institutions argues that trust can become dependency in relationships that occur in the context of inequality such as that between a healthcare provider and a patient. However where institutions have established ethical codes to protect the dependent partner, they “may also provide the basis for the emergence of voluntary trust” (2003: 1454). Given that the obstetric profession is notorious for its mistreatment of women (Murphy-Lawless 1998; Wagner 2006) and given its reluctance to instil evidence-based practices(Enkin 2006; Wagner 2006) and even failure to adhere to its own ethical codes (Christilaw 2006) its questionable as to whether the profession on the whole is ‘trustworthy’. Moreover, the profession’s stranglehold on knowledge, its claim to expertise and the alignment of its values with the broader cultural values of a technocratic modern society (Davis-Floyd, 1992), renders the relationship between women and obstetricians extremely unequal. Reiger and Taylor’s (2005) use of feminist psychoanalysis for theorising the dynamics of power and emotion in obstetric led care is useful here. Their discussion of the intersubjectivity in the maternity care encounter points to the “emotional space” between women and obstetricians as being traditionally characterised as one
of domination and denial of subjective recognition. Moreover, it contains the potential for the doctor to take on the role of “father figure” (2005: 13). Thus women’s relationship with their doctors can be seen as more characteristic of dependence rather than mutual trust (Gilson, 2003). This dependence becomes crucial in women’s birth experiences, but this issue cannot be fully discussed within the limits of this paper.

Mistrusting the birth process

While earlier research reveals that middle-class women use medical interventions to enhance or control their birth experiences, most of the women I interviewed by contrast, expressed strong desires for normal birth (although two women specifically said that they didn’t care about the birth process at all and just wanted to “get the baby out”). Their desire for a normal birth however was tempered by their doubt and lack of confidence in actually being able to birth without assistance. Moreover, most held strong beliefs that birth was not something that could be controlled and therefore medical intervention was always a possibility that couldn’t be excluded. This was highlighted most prominently when women talked about birth plans:

But as far as formal [birth plan] like I want this, I don’t want this, um I’m just going to basically take it as it comes because I can’t predict anything… Louisa, first pregnancy.

There was so many people I knew who had like a birth plan and said ‘I’m not going to do this and I’m not doing that and I’m going to [have] dolphin music and… like really specific ideas about what they wanted and nobody actually ended up with that so I just thought that planning for a birth just seems ridiculous really in a way… you can only plan to
an extent. So we just went into it with it…you just don’t know. Jenna, second pregnancy.

Many women based their views concerning birth plans on the experiences of family and friends. For example Brooke’s three sisters had all had emergency caesareans, thus she felt that “you never knew what could happen” and there was no point being prepared for a “certain kind of birth because you might not get it”. Other women’s confidence to give birth without intervention in subsequent births was eroded due to their first highly medically managed birth experience. For example, Scarlett’s first birth ended in a highly traumatic forceps delivery following the standard route of the cascade of intervention;

The first time I had quite a narrow idea of what my perfect birth experience would be, and I really wanted that outcome; a natural, active birth with lots of movement, hopefully no drugs, that natural euphoria of your own body's endorphins; and for my baby to come into the world with minimal interference. I have since decided that although the process is still important to me, there are factors that I can't control and so I don't want to set myself up for disappointment or put undue pressure on myself.

Scarlett didn’t blame the medical system or her doctor for her traumatic birth experience; she blamed instead the “ideal” of “natural birth”. At the time of interviewing, Scarlett had decided on an elective caesarean for her second baby. Other women also discussed natural or normal birth as an ideal, a “view” or a “philosophy” rather than an actual biological reality. Some researchers have argued similarly, that the natural birth discourse of feminists and consumer advocates sets women up with unrealistic expectations about birth, and to feel like failures when they instead have highly technical births (Frost, Pope et al. 2006). However, this analysis is problematic, as it seems to be saying that women should accept medical control because a ‘natural’ or women-centred birth experience is often unattainable. It also
ignores other important cultural factors. For instance, there would appear to be cultural shift in the way women view their bodies and childbirth—discussions on mainstream internet pregnancy/birth chat forums also show a decline in women’s confidence to birth without medical assistance (see for example www.essentialbaby.com.au).

Reiger and Dempsey discuss the ways the ways in which a “culture of fear” surrounds childbirth in contemporary Australian society, which has resulted in the erosion of trust in childbirth on both cultural and individual levels (2006). They argue that as social processes have direct material/bodily outcomes, in contemporary culture anxiety and loss of confidence “can be seen as producing a normative frame of reference that becomes internalised and, most importantly enacted by individual women” (2006; 6). Germaine Greer noted this loss of confidence when she argued, in the context of the elective caesarean debate, that after years of misogynist medical ideology telling women their bodies were flawed, it was little wonder that women were rejecting normal vaginal birth entirely (Greer 2004).

Obstetricians reinforce the cultural ambivalence toward normal birth and further eroded the women’s confidence in the birth process by treating birth as a potentially dangerous process, instilling doubt in women’s bodies;

And then I think at 26 weeks he started getting worried because I had too much amniotic fluid, I was getting too big, too quick. I was getting all kinds of things…we got to 30 weeks and he said ‘you’re getting too big too quick, too much fluid’…you know we talked about what that could mean. Sandra, third pregnancy
Sandra’s recounting of this discussion with her doctor was characteristic of other women’s stories. For instance, women were told their pelvis might be too small (although this can only be ascertained through a vaginal birth attempt), or that their babies were too big. In many cases, women were told by their doctors not to worry about a birth plan: this was even from the supposedly ‘low intervention’ doctors. For example Sandra’s doctor told her to “forget it” in response to a question about a birth plan and that as far as he was concerned the “plan is to get the baby out”. Jasmine’s obstetrician told her that “only women who don’t trust us use birth plans”. In this way, medical authority is reinforced and women’s own agency/autonomy is undermined.

Conclusion

This paper has argued that women who participated in this research trust their doctors but mistrust the birth process. The women interviewed enter into this relationship of trust based on their belief in the technocratic model of birth and their class positioning and identity as middle-class, educated women. However, the inequality inherent within the woman/doctor relationship and the power of the medical model of birth renders the notion of mutual or voluntary trust problematic; therefore the relationship becomes more like one of dependence. Women’s understandings and expectations of birth are shaped by a culture of fear and ambivalence toward childbirth, which becomes reinforced through the implicit trust they display toward their individual doctors and their faith in medicalised birth.
Bibliography


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