Politics, Power, and Birth
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ABSTRACT
Politics is the process and method of decision making for individuals and groups. Politics may define the power relationships between women and their healthcare providers. Politics may shape the experience for the woman. Nurses and birthing women can learn to negotiate the politics and power relationships surrounding the birth experience.

Key Words: birth, politics, power

Politics is the process and method of decision making for individuals or groups. Although the term is usually applied to governments, politics is observed in all human group interactions. Politics, as a process, is relevant to the interactions between women, their care providers, and their families. Politics as a process is dependent upon the power relationships between groups and individuals.

During the feminist revolution of the 1960s, the slogan “the personal is political” became popular. Nowhere is the personal more dependent upon human interactions and power relationships than in healthcare and in particular, the birth process.

Power relationships became particularly defined, as birth became a process that came out of the home and into the hospital. Where birth had been viewed and accepted as a natural and normal event in the daily life of a family and a community, birth became medicalized, perceived as dangerous, and physician care developed into the gold standard. Sadly, little real change in the evidence-based care of laboring women has taken place in the 20 years that the Journal of Perinatal and Neonatal Nursing has been published. The environment has improved, with private rooms resembling hotel rooms, but women are still continuously monitored even with normal labor, food and drink may be restricted, movement is discouraged, and the cesarean section rate hovers near 30%. Happily, more births are attended by midwives, the episiotomy rate has declined, and water birth and birth centers have increased.

The political progression continues today. The demand by a few women for elective cesarean section, the refusal of some physicians to attend a trial of labor after cesarean, and the condemnation of the home as a safe birth setting are issues that test the practitioners and women who would like to weigh the evidence and make informed decisions regarding labor and birth. The power relationships between women and their healthcare providers limit the choices that women may have and may even constrain the discussion of choices. If the healthcare provider believes that choices should be limited to those the provider feels comfortable providing, other choices may not enter into the dialogue.

Ideally, decision making regarding labor and birth will begin during prenatal care. The antepartum period is a time of exploration and questioning for many women. Care providers can facilitate this learning with adequate time during appointments, concern for a woman’s misgivings, and encouragement. Informed consent may and should initiate a discussion of risks and benefits of procedures and routines.

However, even though informed consent implies an understanding and agreement with a plan of care, too often a woman is influenced by her perception of the healthcare provider as an unbiased expert. This is true of her perceptions of physicians, midwives, and nurses.

We can compare the discussions relating to elective cesarean on demand and the home as a setting for birth, and briefly analyze the politics. Elective cesarean on demand has been defended by physicians as a women’s rights issue. Minkoff explains that physicians should be reluctant to refuse a woman’s request for an elective cesarean birth if the woman is properly informed about the risks and benefits of the procedure. He details the
principles of autonomy and beneficence relating to the relationship a woman shares with her physician. He also reviews the deliberative model. In this model, the physician attempts to guide the woman to choose the optimal course (or the physician’s view of the optimal course) and interventions for her pregnancy, using persuasion rather than imposition of values. However, if the physician does not offer some interventions, he or she may be reluctant to discuss these interventions with a woman, such as trial of labor after a cesarean birth. Conversely, if a physician thinks that some interventions are absolutely necessary, he or she may not even offer the woman a choice or an explanation, such as continuous fetal monitoring during a normal labor. If interventions are routine, imposition of values is implicit, and embedded in the care and the discussion.

Few physicians or midwives discuss birth setting with pregnant women, although midwives may discuss the risks and benefits if the woman asks about home birth. The press release announcing the American College of Obstetricians and Gynecologists’ Opinion on Planned Home Births quotes Dr Richard Waldman, “As physicians, we have an obligation to provide families with information about...the different maternity care providers.” Physicians rarely exercise this obligation to provide families with information about midwives. Politically, this “obligation” to discuss the pros and cons of other healthcare providers attempts to establish the physician as the expected provider of maternity care. A woman’s request to give birth at home does not seem to be a women’s rights issue for physicians.

POLITICS AND POWER OF LABOR AND BIRTH
The politics and power relationships of the labor and birth process may be seen to revolve around the word “allow.” To allow is to make possible through a specific action or lack of action, or to consent to or give permission. The concept of allowance gives the power to the healthcare provider, whether physician, midwife, or nurse and makes the laboring woman dependent upon this allowance. Allowance removes some aspects of choice and consent from the woman and makes her dependent upon the actions and beliefs of the healthcare provider. To define the services one offers to pregnant women using the phrases “I allow” or “I don’t allow” transfers all control to the provider. To “allow” ambulation during labor is to give a tacit approval and to not “allow” a trial of labor after a previous cesarean birth (TOLAC) is to imply that TOLAC is dangerous and imprudent. To “allow” an action implies an authoritarian relationship, similar to a parent and gives political power to the healthcare provider. The concept of allowance signifies that the healthcare provider is the expert, that the provider knows what is best without discussion and that the provider will always make the best decision for the woman. This language extends to nursing also; nurses are “allowed” to perform some procedures in hospitals and not in others. More respectful language would imply mutual consent between the parties in the discussion, or political cooperation and compromise.

Compare the statement “midwives are allowed to attend TOLAC and vaginal birth after cesarean” with the statement “midwives are qualified to attend TOLAC and vaginal birth after cesarean.” Similarly, compare the statement “laboring women are allowed to ambulate during labor” with the statement “laboring women are encouraged to ambulate during labor.” The emphasis moves from permission to active voice.

Nurses experience this concept of allowance in many ways, limiting the procedures they may perform and the assessments they make. The Institute of Medicine’s recent report encourages the use of nurses to the full extent of their education and training. Nurses are not “allowed” to practice but encouraged to use their skills to the maximum ability. This enhancement of the nursing role will benefit patients and healthcare systems. As an example, nurses in some labor and delivery settings are not allowed to check cervical dilatation because the resident needs the experience. This limit of practice not only ignores the training and experience of the nurse, but it objectifies women as learning experiences, not as participants in the birthing experience.

If birth and the relationships a woman has with her healthcare providers can be seen as political experiences, can changes be made using a political approach? The political approach is broad and encompasses many arenas. Political action can be aimed at legislative change, local and societal change, organizational change, and personal change. Legislative actions are not the ideal approach for changing personal relationships but can help to redefine power relationships.

Legislation may define the license of the healthcare provider and set limits on practice. For example, legislation that requires a midwife to have a signed written agreement with a physician limits the midwifery practice to those areas with physicians who are willing and comfortable with signing an agreement. Physicians do not need signed written agreements between themselves to provide collaborative services. Collaboration is expected for the greatest patient benefit. Requiring a profession to seek the approval of another profession builds a power relationship that is detrimental to patient care.

Most states have nursing groups who lobby for support within the state. Physicians are represented by the powerful American Medical Association, which lobbies at the state and national levels. Obstetricians and
gynecologists are also represented by the American College of Obstetricians and Gynecologists and nurses who practice in women’s health are represented by the Association of Women’s Health, Obstetric and Neonatal Nurses. Association of Women’s Health, Obstetric and Neonatal Nurses was formerly the Nurses’ Association of the American College of Obstetricians and Gynecologists. The Association of Women’s Health, Obstetric and Neonatal Nurses left the American College of Obstetricians and Gynecologists and incorporated as its own organization when it became clear that sometimes nurses and physicians may have different political agendas.

The socialization of physicians, nurses, and midwives establishes a norm in the political power relationships with women and between professions. Language may play a key role. Physicians are always referred to as “Doctor,” while nurses and midwives are generally addressed by their first names, both by patients and by other healthcare providers. The use of the title recognizes the expertise of the physician and creates a hierarchy within healthcare. Physician groups may resent the registered nurse who holds a doctorate and may not wish to recognize him or her with the title of “Doctor” even though “Doctor” was originally an academic title. The use of the term “midlevel provider” may refer to licensing but implies that the provider is not of the highest level and may signal to patients that a physician is “better.” Political action around this term may take place organizationally with advanced practice nurses discussing the implications with the organization’s leadership. Discontinuing these terms may take time but will ultimately be useful and clearer for patients and organizations.

SUMMARY
In summary, politics as a method of decision making in the birth process may be overt and recognized or implicit and sanctioned by existing relationships. Informed consent is affected by power relationships that impact on the true information given and options presented. Awareness of the political nature of relationships can help the healthcare provider begin a dialogue with a woman that respects the woman’s options and choices.

There are many different degrees of political action. Nurses, midwives, and nurse practitioners can participate at a level at which they are comfortable and feel effective. Ignoring or denying the existence of power relationships ignores the need for change. Basing decisions on evidence can improve the birthing experience for all women.

References