Choices for Childbirth: A Survey of Practice in Melbourne Maternity Hospitals

This paper describes a survey of childbirth practices in Melbourne hospitals. Information was collected from 27 of Melbourne’s 34 hospitals with obstetric beds. The survey concentrated on aspects of the management of labour and the newborn where patients could expect to exercise a degree of choice.

The survey found large variations in the degree of choice offered to patients in different categories of hospital on more than half the questionnaire items. Patients in large public hospitals were in general given the largest range of choice, followed by private hospital patients. Patient choice was very restricted in most small public hospitals.

For some time, ante-natal classes have been available at the Western Region Health Centre for any interested members of the community. Several local hospitals refer women to these classes, and, in group discussions, it became obvious that childbirth routines and practices varied considerably between different hospitals.

It was felt that a survey of current childbirth practices in hospitals likely to be used by western suburbs women would be the best means of obtaining accurate and fair information for women attending ante-natal classes. The information was also needed for a proposed series of classes, 'Choices for Childbirth', to be given by members of the Footscray Women's Health Group at the Western Region Health Centre.

In general, the authors' intention was not to discuss the relative merits of particular methods of practice. However, we have provided brief indications of the merits of procedures that may be regarded as innovative, in order to support their status as legitimate alternatives for parental choice. We did not feel that this would be solely the responsibility of the private practitioner, rather than a reflection of hospital policy.

Method
The survey was conducted by postal questionnaire (see Appendix). The questionnaire contained 44 checkbox format items. Additional comments were invited.

About half the questions concerned ante-natal care and labour management, and the remainder related to baby management. The questionnaire concentrated on areas where parents now expect to exercise a degree of choice (Lumley 1980). It was felt that answers to these questions would tend to reflect general medical and nursing preference and hospital policy, rather than the practice of individual doctors. Subjects which are generally considered to be primarily individual medical decisions (eg. indications for Caesarian or forceps delivery) were not covered.

Private hospitals were not asked to estimate percentages of patients who receive electronic monitoring or episiotomies, as it was felt that this would be solely the responsibility of the private practitioner, rather than a reflection of hospital policy.

Initial Survey
The initial questionnaire was sent on 3rd August 1982 to all western suburbs hospitals with obstetric beds (7), and to four inner city hospitals used by women in the western suburbs. Follow up letters were sent to those hospitals that had not replied after 6 weeks.

Second Survey
The results of the initial survey were so interesting, that we decided to extend the survey to include all Melbourne hospitals with obstetric beds. A list of 23 additional hospitals was obtained from the Health Commission of Victoria.

On 22nd November 1982, questionnaires were sent to these hospitals. Two follow-up letters were sent to hospitals which did not reply.

Response Rate
Replies were received from 27 of the 34 hospitals in the survey group (79.4%). Five did not reply, and two (both public hospitals) informed the authors in strong terms that they did not regard such a survey as legitimate.
Hospitals were grouped into five categories: teaching hospitals specializing in obstetrics and gynaecology ("specialist maternity"), large public general hospitals, small public, large private and small private hospitals. Small hospitals were defined as those with twenty or fewer maternity beds, and large hospitals as those with 39 or more. No responding hospitals had between 21 and 38 maternity beds (see Table 1).

The response rate to the initial survey (90.9%) was higher than that of the follow-up survey (73.9%), probably because the results of the initial survey were to be used for patient education, and because the Western Region Health Centre is known to hospitals in the western suburbs.

Results
The questionnaire covered 44 items of information. Unanimous or almost unanimous replies were received to ten.

Unanimous or Almost Unanimous Responses
All hospitals allowed the woman's partner to be present during labour. None used intravenous drips routinely, and all but two (both small public hospitals) allowed the woman to move around freely during labour. All but one hospital routinely used ergometrine or syntocinon to contract the uterus after delivery.

All hospitals allowed the couple some time alone with the baby after an uncomplicated delivery, and permitted breast feeding immediately after vaginal delivery. Twenty four hospitals (88.9%) stated that they encouraged immediate breast feeding.

Roombing in during the day was permitted by all hospitals, although in two small hospitals this was allowed only in private rooms. Mothers were permitted access to the nursery, and to sick and premature babies at all times in all hospitals but one. All hospitals allowed fathers access to the nursery, and to the special care nursery if one existed.

Differing Responses
A wider range of responses was received to the remaining 34 items. For ten of the questions, large differences were not observed between the different categories of hospitals.

Table 1 shows hospital policies on partners' presence during internal examinations and forceps deliveries.

Table 2: Partner required to leave

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Depends on Doctor</th>
<th>Never</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Exam.</td>
<td>4 (14.8%)</td>
<td>6 (22.2%)</td>
<td>13 (48.1%)</td>
<td>2 (7.4%)</td>
</tr>
<tr>
<td>Forceps</td>
<td>2 (7.4%)</td>
<td>8 (29.6%)</td>
<td>15 (55.6%)</td>
<td>2 (7.4%)</td>
</tr>
</tbody>
</table>

Seven hospitals (20.6%) allowed someone other than the father to be present during labour.

A wide range of attitudes to electronic foetal monitoring was apparent. Electronic monitoring (internal and external) was unavailable in three small hospitals (two public, one private). In all hospitals where internal monitoring was available, it was stated that the decision to use it was made by the doctor concerned; two hospitals stated that the patient's choice was also a factor. Five hospitals (20.8%) stated that the patient was given a choice about the decision to use external monitoring (see Table 3).

Large variations in rates of use of electronic monitoring are evident. In particular, one specialist hospital used electronic monitoring in less than 25 per cent of cases, while a small hospital used it in more than 75 per cent. This is difficult to reconcile with the relative obstetric risks of the patient populations.

Stirrups were usually used for delivery in four hospitals (14.9%), sometimes in fifteen (55.6%), rarely in six (22.2%) and never in one. Only one hospital stated that patients were given a choice.

Episiotomy rates, like those for monitoring, varied a good deal between hospitals (see Table 4).

Routine aspiration of the baby's respiratory passages was carried out by 18 hospitals (66.7%).

Sleeping pills were prescribed routinely during the post-natal period by five (18.8%).

Responses in Different Categories of Hospitals
Striking differences between different categories of hospitals were observed on the remaining 24 items. These differences were tested using Fisher's Exact Test, and 19 were found to be statistically significant at the .05 level. Since extreme differences are required to achieve statistical signifi-
cance with such a small survey group, we considered that the differences recorded on the remaining five items had sufficient practical significance for the consumer to merit discussion.

On fourteen items, the practice of the small public hospitals differed from that of the remaining hospitals; ten of these differences were statistically significant at at least the .05 level.

Partners were more likely to be asked to leave during a caesarean delivery with epidural anaesthesia; 75 per cent of small public hospitals always required this, compared with 23.5 per cent of other hospitals (p<.05). Leboyer style delivery (complete or modified) was available in two small public hospitals (25%) and 88.9 per cent of other hospitals, including 87.5 per cent of small private hospitals (p<.01). Patients were less likely to be offered a choice of delivery positions in small public hospitals (12.5%) than in other hospitals (63.2%) (p<.05).

Rooming-in at night was virtually unobtainable in small public hospitals; one public hospital allowed it in private rooms only. In contrast, rooming-in was available to all patients in 68.4 per cent of other hospitals and to some patients in a further 26.3 per cent (p<.01).

Demand feeding was encouraged by two small public hospitals (25%) and permitted by the remainder. However 94.7 per cent of the remaining hospitals encouraged demand feeding (p<.01).

Small public hospitals were far less likely than other hospitals to permit or encourage fathers to participate in activities such as bathing the baby or changing nappies. Fathers' participation in baby care was not encouraged by any small public hospital, and was not permitted by 5 (62.5%). In contrast 14 (74%) of the other hospitals encouraged participation and only one did not permit it.

The baby was removed from the mother's room during visits in seven of the eight small public hospitals (87.5%) and in seven of the other hospitals (38.9%) (p<.01).

Discharge of the patient within twenty-four hours of delivery was discouraged by all small public hospitals, and by 63.2 per cent of other hospitals (p<.05) Advice on post-natal contraception was given to patients in 37.5 per cent of small public hospitals and 94.1 per cent of other hospitals, including 87.5 per cent of small private hospitals (p<.01).

The following differences did not achieve statistical significance. No small public hospital allowed patients' children to be present during labour; seven of the other hospitals (38.9%) permitted this. Partners were always requested to leave during a Caesarean delivery under general anaesthesia by 75 per cent of small public hospitals and 35.3 per cent of other hospitals.

Pethidine was the most frequently used analgesic in 75 per cent of small public hospitals and 43.7 per cent of other hospitals. (The remaining hospitals used nitrous oxide most often.) No small public hospital allowed the mother to have her baby in bed with her except when nursing; 49.1 per cent of other hospitals permitted this.

Seven items showed large differences between the practice of small hospitals (both public and private) and large hospitals. Six of these differences were statistically significant.

Not surprisingly, all large hospitals had an ante-natal education programme, compared with 52.9 per cent of small hospitals (p<.05).
The flat dorsal position for delivery was used in ten small hospitals (38.8%) but only in one large hospital (p<.05). Small hospitals were more likely to give supplementary feeds routinely (88.2%) than large hospitals (40%) (p<.05).

Access of relatives other than parents to nurseries tended to be restricted in small hospitals. All but one of the large hospitals allowed grandparents and siblings access to both the ordinary and special care nurseries. Only four small hospitals (all private) allowed parents access to the nursery; three (also private) allowed siblings access (p<.01). Twelve of the seventeen small hospitals had special nurseries; three allowed grandparents access and two permitted siblings (p<.01).

More restrictions were imposed on visitors in small hospitals, although these differences were not statistically significant. No large public hospitals restricted visits from patients' partners or children, while three small hospitals restricted partners' visits and four children's. There was no noticeable difference between hospital categories regarding visits from family members other than parents and children (restricted by 26.9% of hospitals) or friends (restricted by 76.9%).

On three items, differences were observed between the general public hospitals, both large and small, on the one hand, and the private hospitals and the specialized maternity hospitals on the other.

Shaves and enemas remain routine in almost all public hospitals other than specialized maternity hospitals, despite the absence of evidence for their usefulness (Kantor 1965). In contrast, patients in private hospitals were usually given a choice.

The large variations in the rate of electronic monitoring are also interesting. Although external monitoring is generally believed to be less accurate and as restrictive as internal (Lumley 1980), it is used more frequently. Rates of monitoring did not seem to reflect varying degrees of risk in patient populations, and women were rarely given a choice about the decision to monitor.

Variations between Categories of Hospitals
Women giving birth in small hospitals, especially small public hospitals, have fewer choices concerning a wide range of issues than women using other hospitals. In some cases, practices which are increasingly regarded as beneficial in the management of childbirth and the newborn were not permitted.

The use of the flat dorsal position for delivery by more than half the small hospitals is cause for concern in view of the disadvantages of this position; compression of the major blood vessels, uneven stretching of the perineum and decreased efficiency of contractions (Schwartz 1979, Kitzinger 1980, Noble 1978). In addition, only one small public hospital offered patients a choice of delivery positions.

The preference of three-quarters of small public hospitals for pethidine as an analgesic rather than nitrous oxide is also interesting. Pethidine has a far greater effect on the baby's respiratory function than nitrous oxide (Rosen 1977, Kitzinger 1980). In addition, the patient is dependent on nursing staff for the administration of pethidine, while nitrous oxide is administered by the patient in accordance with her perception of the need for analgesia.

While Leboyer delivery has not been shown to affect birth outcome in any measurable way (Lumley 1980), it is clear that this approach to birth has a great deal of appeal for many parents. It is hard to understand why small public hospitals should be unable to offer this option when almost all small private hospitals do.

Baby management policies were also more restrictive in small public hospitals. Patients were offered the option of rooming in at night in very few small public hospitals, although almost all other hospitals permit it. This policy not only represents a denial of choice to the patient, but may tend
to discourage breastfeeding. The discouragement of demand feeding by small public hospitals, together with the routine complementary feeds common in small hospitals, may also hinder the establishment of lactation (NMAA 1975, Kitzinger 1979).

While parents had good access to the baby in all categories of hospital, small public hospitals tended to limit the practical involvement of fathers with their babies. Unlike other categories of hospital, all small public hospitals discouraged fathers from bathing or changing their babies; in fact the majority forbade it. This policy seems likely to discourage men from helping to care for their children by preventing them from acquiring skills and confidence while the baby is still in hospital. It also reinforces the belief that childcare is exclusively women's work.

The involvement of children in the birth of a sibling was restricted by many hospitals. Children were not allowed to be present during delivery in any small public hospital, or two-thirds of other hospitals. Most small hospitals did not allow children access to nurseries. Since, in addition, most small public hospitals removed the baby from the mother's room during visits, it would appear that the children of women using these hospitals had little chance to get to know the new baby.

The failure of the majority of small public hospitals to provide advice on contraception before discharge gives serious cause for concern. Although conception before the six-week postnatal check may be uncommon, the possibility should not be disregarded. There seems to be no obvious reason why this service can be provided in similar sized private hospitals, but not in public ones.

Conclusion

The major finding in this survey is that the amount of choice women have over the management of labour and the newborn is strongly influenced by the type of hospital in which they give birth. In general, the greatest degree of choice is offered by large public hospitals, including specialist maternity hospitals, followed by private hospitals, although some exceptions to this were observed. Small public hospitals provided a very limited range of options, particularly concerning baby management and feeding practices.

Of course, all women are not equally free to choose which hospital they will use, for both financial and geographical reasons. While there are five private hospitals in any small public hospital, or two-thirds of other hospitals. Most small hospitals did not allow children access to nurseries. Since, in addition, most small public hospitals removed the baby from the mother's room during visits, it would appear that the children of women using these hospitals had little chance to get to know the new baby.

For these reasons, it is to be hoped that small public hospitals will consider offering their maternity patients a greater range of choice in the future. Hospital practices have changed greatly during the past fifteen years; the presence of partners during labour, Leboyer style management of birth, and rooming-in are obvious examples. However, most hospitals retain some routines and restrictions for which the necessity is not immediately apparent. We hope that all hospitals will continue to re-evaluate these practices in order to increase women's control over the way in which they give birth.

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Armstrong and Helen Harden for support, advice and encouragement.

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Appendix

Western Region Health Centre
Survey of Childbirth Practice
Public Hospital Questionnaire

Some questions may require several boxes to be ticked. Please feel free to add any additional comment necessary to clarify your reply

Part A. General Information
1. Name of hospital
2. Number of maternity beds
3. Position of person completing questionnaire
4. Are beds available to General Practitioners who practise obstetrics?
   □ YES □ NO

Part B. Ante-Natal
1. Does the hospital conduct an ante-natal programme?
   □ YES □ NO
2. If so, does the programme include:
   □ exercise sessions
   □ nutritional advice
   □ relaxation techniques
   □ anatomy and physiology of childbirth
   □ breast care and preparation for breast feeding
   □ preparation for parenthood
3. Is the patient seen by the same practitioner at all ante-natal visits?
   □ Always
   □ Usually
   □ Not usual

Part C. Labor
1. Are the following permitted to be present during labour:
   □ husband/partner
   □ other friend/family member
   □ children
2. Are partners required to leave during:
   □ internal examination
   □ forceps delivery
   □ Caesarian delivery
3. Is Leboyer delivery available?
   □ Yes
   □ No
   □ To private patients only

1st Stage
4. Is the administration of an enema:
   □ standard practice
   □ carried out at the doctor's request
   □ left to the patient's choice
   □ not usual
5. Is perineal shaving:
   □ standard practice
   □ carried out at the doctor's request
   □ left to patient's choice
   □ not usual
6. When shaving is carried out, which is more usual:
   □ full shave
   □ partial clipping
7. Is the patient allowed to move freely or walk about during labour?
   □ YES
   □ NO
8. Are food and fluids permitted during labour?
   □ YES
   □ NO
9. Is an intravenous drip used routinely during labour?
   □ YES
   □ NO
10. Is internal foetal monitoring available?
    □ YES
    □ NO
    If so, is it used:
    □ in all cases
    □ at the discretion of the doctor/midwife
    □ at the patient's request
11. Is external foetal monitoring available?
    □ YES
    □ NO
    If so, is it used:
    □ in all cases
    □ at the discretion of the doctor/midwife
    □ at the patient's request
12. Approximately what percentage of patients receive internal monitoring?
    □ less than 25%
    □ 25-50%
    □ 50-75%
    □ more than 75%
Choices for Childbirth

13. Approximately what percentage of patients receive external monitoring?
   □ less than 25%
   □ 25-50%
   □ 50-75%
   □ more than 75%

14. Rank the following analgesics in order of frequency of use:
   □ nitrous oxide
   □ pethidine
   □ epidural anaesthesia
   □ pudendal block
   □ other (please specify)

2nd Stage:
14. Are any of the following positions preferred for delivery:
   □ left lateral
   □ flat dorsal
   □ propped dorsal
   □ squatting
   □ patient given choice of positions

15. Are stirrups used during delivery?
   □ usually
   □ sometimes
   □ rarely
   □ never
   □ according to patient's choice

16. What percentage of patients receive an episiotomy?
   □ less than 25%
   □ 25-50%
   □ 50-75%
   □ more than 75%

17. Is epidural anaesthesia available for elective Caesarian delivery?
   □ YES
   □ NO

18. Is epidural anaesthesia available for emergency Caesarian delivery?
   □ YES
   □ NO

Part D. After the Birth
1. Is ergometrine or syntocinon used to contract the uterus after delivery?
   □ usually
   □ sometimes
   □ rarely

2. Is breast feeding soon after vaginal delivery
   □ encouraged
   □ permitted
   □ not permitted

3. Is breast feeding soon after Caesarian delivery
   □ encouraged
   □ permitted
   □ not permitted

4. Is aspiration of the baby's respiratory tract routinely carried out?
   □ YES
   □ NO

5. After a normal delivery are the parents allowed some time alone together with the baby?
   □ usually
   □ sometimes
   □ rarely
   □ never

6. Is rooming-in during the day
   □ available to all patients
   □ allowed only in private rooms
   □ not available

7. Is rooming-in at night
   □ available to all patients
   □ allowed only in private rooms
   □ not available

8. Is the mother permitted to have the baby in bed with her?
   □ YES
   □ NO

9. Is demand feeding
   □ encouraged
   □ permitted
   □ not permitted

10. Are supplementary feeds given
    □ on 1st day
    □ at night
    □ day and night
    □ to small or sick infants only

11. What percentage of mothers are breast feeding when they leave hospital?
    □ less than 25%
    □ 25-50%
    □ 50-75%
    □ more than 75%
12. Are sleeping pills routinely prescribed during the post-partum period? □ YES □ NO

13. Is access by the mother to a baby in the nursery encouraged at all times? □ YES □ NO

14. Is access by the mother to sick or premature infants encouraged at all times? □ YES □ NO

15. Which of the following (tick more than one if necessary) are permitted access to the nursery?
   □ fathers
   □ grandparents
   □ siblings

16. Which of the following are permitted access to the special care nursery?
   □ fathers
   □ grandparents
   □ siblings
   □ no special care nursery

17. Is active participation by the father in the infant’s care (e.g. bathing, nappy changing) encouraged □ permitted □ not permitted

18. Are there restrictions on visits from
   □ partners
   □ patient’s children
   □ family
   □ friends

19. Is the baby removed from the mother’s room during visits? □ YES □ NO

20. Is early discharge (within 48 hours of delivery) not encouraged □ left to patient’s discretion

21. Is information on post-partum contraception given before discharge? □ YES □ NO

Private Hospital Questionnaire
This was identical to the above, except that two questions were added to Part A, namely:

Accommodation cost per day: a) shared ward b) private room

Are there any additional hospital charges, e.g. theatre fees or nursery fees? □ YES □ NO
If so, please specify nature and amount of charge.

Also, questions 12, 13 and 16 were omitted from Part C.