

THE POWER OF WORDS – IT'S WHAT YOU SAY AND HOW YOU SAY IT

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A Hole Called Amanda

Amanda had come in to be induced. Amanda was a private 'patient' and had requested her induction. She had also organised with her doctor to have an epidural administered as soon as she started to contract. I (at that time a midwifery educator) was called in to assist her midwife to set up for the epidural. Essentially I was a pair of hands. There was a student midwife in the room, who had not had enough 'witnesses' and so she 'wasn't allowed to conduct the delivery', and besides, Amanda was private, and her obstetrician would 'deliver the baby' as student's were definitely not allowed deliver private women!

There was a lot happening on the ward at the same time, so I would not be staying with Amanda, and had planned to leave as soon as I was not required further. Her midwife, Megan, had cared for Amanda since the beginning of the shift. After I had said hello, Amanda told me she felt she had her epidurals too late with the other two births, and she hated those births – felt caught up in something that she felt was overwhelming, and that she did not have good memories of. It was important to her that she enjoy this birth, because she said it was her last. The anaesthetist arrived very promptly and put in the epidural – adding his bit about it being a 'wise' decision....and that epidurals were man's gift to women...

Shortly after the epidural had been administered, Amanda began to work hard. As I was preparing to leave the room, I turned back....

There was Amanda's husband, her sister, the midwife, the student midwife and the obstetrician. I became aware of what each of them was doing. I

listened to what they were saying, and I watched what was happening. I looked at what they were watching, for what they were doing, was watching an opening, not Amanda. It was extraordinary - everyone seemed focussed on her vaginal opening, waiting for the baby to show itself. Amanda was on her knees and elbows, with her face buried in her hands.

As everyone watched her vaginal opening, they were telling it how to push, where the push was needed, and when to push. "I can see a little bit of the baby's head now", Megan the midwife said to it. "I need a bit more of a push - stronger now!" she said to the hole. Amanda's partner said "Mandy I can see it! Oh this one's a hairy little bugger!". The student midwife couldn't take her eyes off Amanda's vaginal opening – she was spellbound! Her sister said "Almost there - come on baby, come on baby!", and the obstetrician said "The perineum is stretching up well Amanda - a lot of burning and pressure now". I heard Amanda so softly say, "I can feel her coming - here she comes". No one else seemed to have heard what she said –they continued to speak to Amanda's vagina and the baby's head. These words sound strange to me even as I write them, wanting to keep this memory alive for a moment just such as this.... Maybe Amanda's words were not meant for my ears, or anyone's ears, but were spoken for her and her daughter alone – I don't know.

But it seemed to me, as the baby neared, that everyone was so caught up in the moment that Amanda (the woman) disappeared as they waited for *the baby to show itself*. In truth, *Amanda* was showing the baby to them. Although - she was bringing the baby down, pushing it through her - giving birth, it seemed as though they all cajoled her vaginal opening - almost as if it were independent of her - to push, to open and for the baby, also independent of her, to show itself. They didn't appear to actually "see" Amanda. They saw an opening a hole - and spoke to that, but called it Amanda. In their excitement at the nearness of the babe, they didn't hear what they were saying - how they said it, or where their words were directed – they didn't hear Amanda when she murmured those words, telling them what was happening inside **her**, inside Amanda. She, Amanda, the woman, the person, was telling them her

daughter was coming, but they didn't hear her telling them – they were busily focussed on the hole that they called Amanda - not on Amanda as a whole.

Student Midwife's reflections on VBAC28th April

Today I witnessed how a doctor's words and actions can strongly influence a woman's care. Sally, a G2P1 came in, in early labor planning to have a VBAC. I realize that uterine rupture is a known hazard regarding VBAC. But listening to the doctor talk you would think it would always happen and that no one delivers safely with VBAC. I kept trying to reinforce how women do successfully have vaginal births after LSCS and even though he said he would support her no matter what her decisions, but his actions and words contraindicated this. He had the lady so scared she was even afraid of sleeping in the ward in case her uterus ruptured. He informed her that there was an increased delay from the ward to the OT. I felt angry that he had petrified this woman so much that the option of VBAC was no longer an option. However I put aside my anger and supported this family in the decision, as it is their baby that could be at risk and their birth experience – so I wanted to make it as positive an experience as possible. While in OT during the LSCS the doctor, as if to validate his fear tactics said in a loud voice – “look how thin this lower segment is and the woman not even in established labor”. However in my opinion the end does not justify the means. This scenario has shown me how the words if chosen in info giving can strongly impact on the woman's care. In this case she went from being empowered in deciding to undertake a VBAC to undertaking a passive role and electing LSCS as a result of the language used and the communication between her and the doctor.

Good morning! The two pieces I have just read to you serve as a starting point for this paper – The Power of Words. These scenarios actually occurred and illustrate how language shapes what we do, how we do it, and how it can affect women to varying degrees in maternity care.

There has been extensive inquiry into the medical and midwifery models of maternity care, and language forms part of that care. The language of

maternity care has evolved in its present form directly as a result of the medicalisation of childbirth, the development of the field of obstetrics, and the subsuming of midwifery into nursing, which also was framed by the medical discipline. It is a language that inadvertently (or advertently) serves to objectify women and reduce them to a series of dismembered organs and spaces, partly illustrated by Amanda's experience described above. I believe however, that language does even more. I am sure you know not only does it dismember women to a series of organs and spaces, it pathologises women – rendering them inadequate, incapable of growing a baby, of labouring, giving birth without assistance, even capable of harming her baby through labour and birth. Language goes even further than this – it can demote women anywhere from totally visible and make them opaque by degrees to total transparency and invisibility.

In 1992 I came across a book called “Living Laboratories – Women and Reproductive Technology” written by Robyn Rowland. I urge you to try and access a copy of this book, unfortunately no longer in print. Her work with women, who have had multiple “failed” cycles of IVF, deserves highlighting. She devoted a whole chapter to what she termed ‘Reprospeak’ - the terminology used in the field of Assisted Reproductive Technologies (ART), and I would like to share with you some of the terminology she uncovered.

Firstly, she identified how, in the application of new and sometimes astounding reproductive technologies, the focus of care and ‘treatment’ brings **fetal personhood** to the fore and **pushes women into the background**. The language surrounding the use of these technologies and other interventions helps to create, shape and perpetuate our birthing culture and often disconnects woman from her unborn and newly born completely.

An advertisement for a Fetal Trace Transmission System by Hewlett-Packard in OB Gyn News, reads “the system allows rapid transmission and receipt of fetal heart traces – real time or recorded – over standard telephone lines....hard copy data need not be viewed at different locations simultaneously – the woman, of course need not be viewed at all”. The ad

shows a large photograph of a childlike looking fetus with the caption “Today Jennifer made her first long-distance phone call.” (Rowland 1992)

Another example “twelve oocytes were retrieved after ovarian stimulation by an association of gonadotrophin-releasing hormone analogs and human menopausal gonadotrophins” (in Sashar, 2001).

And “It is estimated that over 40,000 ovarian cycles are stimulated with gonadotrophin preparations annually in the UK, either for assisted conception or for conventional induction of ovulation”.

These are examples of invisible women. Some that undermine women include “Even my obstetrician, he said all along that I wouldn’t be able to have a natural birth – he said ‘you know I really don’t think you’ll be able to’. Every time I had an appointment he kept asking me about my foot size. I thought that was really bizarre. I don’t remember what they discuss with you each time you go in but he would bring it up every time. It was his way of warning me I think. He said if you’ve got a small foot you’ve got a small uterus and pelvis. I just figured that the baby’s head would be too big”. (Marnie)

“He said the baby was looking too big when I was 32 weeks pregnant. Right then he told me I should give serious thought to a Caesarean. He said ‘if it’s this big now you will never fit it through’.” (Jillian)

These quotes are taken directly from research I have undertaken for the past 18 months – my Honours work. I have been researching women’s experience of Caesarean, and have interviewed 103 women in depth about the reasons for their CS, their experience of CS, and how they would choose to have their next baby. I have enough rich information – women’s accounts of their experiences - for several books believe me! From 103 women, I concentrated on ten women who for a first pregnancy requested a Caesarean in the absence of a medical indication. I focussed my work on these women because of the debate and opinion pieces about the right of women to choose

a CS in the media, and in medical and midwifery journals. Information from the other 93 women will be written up in future publications.

These women shared their experiences with me in great detail, and a quick overview of my findings shows that the underlying reason for the choice for CS was fear. I had to dig deep to discover this, as only two women volunteered this up front. While the other women openly disparaged vaginal birth, it became apparent that they were also fearful of some aspect of labour and birth. Women normalised CS and pathologised vaginal birth. In fact they compared CS with the most complex vaginal birth imaginable, and not with normal vaginal birth. Women's personal definitions of giving birth defended their choice and were reflected in their decision for a CS.

Many interesting issues surfaced during the course of this research that relate to language. Media representation of vaginal birth and CS was one influence on women's decisions. Women commented about the open discussion about CS in the media nowadays. Headlines such as "Express delivery: is nature's way of giving birth becoming obsolete?" (Hamilton, 2003), "Caesarean: the birth of choice" (Ketchell, 2002), "Push gets the shove" (Fynes-Clinton, 2002), highlight the image of CS depicted by the media. "Women labour over how to give birth" (Gardiner, 2004), "The baby business: why doctors don't want to deliver" (Laurie, 2003), and "Labour disputes. Natural birth or caesarean...?" (Cassrels, 2001), and "No easy way out" (Muller, 2005), depict CS as positive, increasingly acceptable, and a normal way to give birth. Participants stated that these articles influenced them to make up their minds about their choice for CS.

It was not only the frequency with which the articles appeared, but also the argument that held sway with some participants. The benefits of elective CS, such as safety, control, and the avoidance of the pain of labour were inscribed by phrases such as "Australian specialists say the operation has been refined...the operation is pain free...small bikini line incisions replace unsightly vertical cuts.... infection rates have reduced" (Cassrels, 2001).

In contrast, vaginal birth was subverted, pathologised, and portrayed as difficult, dangerous and unnecessary, through phrases such as “Why suffer the agony when your offspring can be delivered without fuss?” (Cassrels, 2001), supporting the notion that CS is an easy and painless way to have a child. Most articles include mixed obstetric opinion about CS, that ranges from “It should be considered a normal way of birth” (Hamilton, 2003) to “Medical practitioners should only be suggesting patients have a caesarean if the clinical condition warrants it” (Odgers & Riggert, 1999). The normalisation of CS is well supported by the authors of a recently written book (Moore & de Costa, 2003). The authors (two obstetricians) claim that a CS is ‘simply another way to give birth’.

Late last year, attention was drawn to the ‘skin-to-skin Caesarean’ instigated by Fisk in the United Kingdom (Moorhead, 2005), (who also, incidentally describes a CS incision as a “nice, clean cut”). This is a Godsend to women who are unable to give birth vaginally, and who want their birth to be as meaningful as possible. However, disturbingly he has refashioned CS to mimic ‘normal’ vaginal birth as closely as possible, making the option of skin-to-skin CS attractive, and ‘just like a normal birth’. It also means, in an almost perverse parody, in which his hands become the vagina, for he squeezes the baby as it comes through the incision, and he ‘lets’ the baby come through a little at a time. This is perhaps the most extreme example I have found of the normalisation of CS, and may serve to further validate women’s choice for a non-medically indicated CS. An obstetrician pioneered it, and already the media has coined the term “natural” caesarean section.

Significantly, and aside from the media hype about CS, *doctors supported women’s fear of vaginal birth* in two ways. First was their acceptance of women’s request for CS without exploring their reasons, and second was how doctors used what I have called ‘**postscripts**’, in their discussions. For example Amelia’s doctor provided her with a discussion on the pros and cons of having a CS and a vaginal birth, but added she might have “bladder problems” (if she chose a vaginal birth). Deanne’s doctor told her six months into the pregnancy (after she had made the decision for a CS) “oh, if we let

you have a natural delivery, the result would be interesting.” When Deanne asked what he meant by ‘interesting’, she was told “probably a difficult labour with either resulting forceps or a Caesar at the end.”

These ‘post scripts’ or ‘afterthoughts’ that doctors added onto the discussion, reinforced women’s fears and validated the ‘choice’ for a CS. If CS did not carry the dangers of vaginal birth (as implied by doctors postscripts), and the doctors either encouraged or at least did not discourage choice of CS, it was reasonable for women to assume that the choice for CS was acceptable.

The language that was used by hospital staff around CS was telling. They reinforced CS through the use of words or phrases as normal. When women questioned uncomfortable sensations that they experienced, not only did staff reassure women that what they were experiencing was ‘normal’, they in fact inadvertently negated women’s legitimate expressions of discomfort by these comments.

Annette talked of how “operating theatre staff acted like it was a normal thing to do...like it was routine and an everyday event. Even my doctor said ‘this is all routine’”. Vera said “They carried on just like they were putting petrol into a car type thing. Just a normal everyday thing. It was a very normal experience...they didn’t make a big deal out of it, and neither did I”. Katrina, Jane and Prue emphasised that it was “not like it’s major surgery or anything like that”.

Women reported being told, “this is all normal”, or “that is just routine procedure” when they asked about noises, activity, feelings and sensations they experienced, and snippets of conversation they heard during the procedure. Although it did not feel normal to them, they were left with the impression that it must be normal. Similarly, as they left the operating theatre, they were told at the conclusion of the surgery that “all went normally”, or “it was a routine or normal CS”.

Two intriguing aspects of this research were issues around bodily integrity and the needlessness of the vagina for birth. Another was the way that women described other women who had a vaginal birth. Terms such as '*Women who had not had a CS*' were used. In addition, instead of using words like vaginal birth, women spoke of it as 'the other', and 'the other way'. Implicit in this was that CS was *the* way to birth and vaginal birth became 'the other way'. In fact, women never spoke of *normal* vaginal birth, or even of vaginal birth *as* normal. Not only was vaginal birth subverted, most obviously expressed through comments such as 'having it vaginally is not important', in language vaginal birth was also pathologised. Women used descriptors of labour and vaginal birth that included failure, precarious, unpredictable, uncontrolled, dangerous, risk, trauma, and injury. Their words echoed the medical discourse surrounding birth which is heavily imbued with negativity and risk (Kirkham & Perkins, 1997; Page, 2004; Shildrick, 1997). Moreover, and observed by others (Martin, 1992; Raphael-Leff, 1993), in their discussions of their fear of birth injury, women used words that embellished trauma potential, for example shattering, exploding and being blown open to smithereens.

Conversely, the descriptors women used as they discussed CS, although not expressly positive, tended to be neutral. These included safe, reasonable, routine, everyday, predictable, prepared, efficient, fuss-free, minimal damage, straightforward, good outcome guaranteed. Women felt CS was less emotional than they thought it would be. Coupling this feeling, with these fairly neutral terms, it was disturbing to discover that these were the words women used to describe what should be a pivotal life event. In addition, women used minifisms (Lawler, 1997), to downplay the risks of CS and the significant complications suffered by four women.

In light of these findings, I put forward that these women reconfigured birth by having their bodies reconstructed by CS for their baby born.

To date, information on medical discourse has related to the language of professionals, (but not women), and has identified that language and naming

are very powerful in shaping the attitudes of a society, since it helps to set the context. In addition, the language of maternity care is particularly negative, readily defines women as defective (incompetent, failure to...), and portrays a desire for control over women and reproduction (managing, complying, trial of...). It dismembers women (cervix, ovaries, perineum not only as separate entities, *but separate from the woman-self*), objectifies (uterus, contractions, cervix and its ability to dilate) and controls them (allow her to walk in labour, refuses instead of declines an oxytocic, or forces on her a time frame within which she must accomplish X).

Not only does this have the potential to legitimise doubt in the midwife or obstetrician's belief in a woman's ability to give birth to her baby, it can undermine a woman's belief in herself.

So where do we go with this? A good place to start is at the beginning. That sounds very simple and obvious, but where is the beginning? What is the beginning? Is there more than one beginning? I believe there is.

I said to one of my colleagues (an obstetrician) one day "You have a number of women booked who have very complex issues at the moment." He looked at me quizzically and said, "Do I? You must ask the questions" This is one of my beginnings, for every encounter with a woman is a beginning - making sure women have opportunities to talk. Another beginning is about making sure I ask questions - finding out what expectations women and their partners have about themselves, and us; what they think about birth, or parenting or being pregnant. It is asking at antenatal visits, and in antenatal education or twin birth sessions, what is important to them. If they have had previous birth experiences, what was meaningful to them and what was not? When you ask women and men these questions, sometimes they respond as though they were giving you a medical history, and their conversation is steeped in medical terms, and sometimes their story comes straight from themselves – in their own words. Equally how you respond to them will determine how well you connect with them and what they do with the information you each share.

If a woman tells you:

- During her last labour her doctor told her that she had a ‘similar stretch’ to someone who tore badly last week and which took hours to fix. That she was given an episiotomy and lost a huge amount of blood?
- That her medically advised caesarean was because she had a ballerina’s perineum, or because she was told that she had a juvenile cervix?
- That at an antenatal education session, the childbirth educator flipped through the picture of positions for active birth in a few minutes and then said “you probably won’t need to know any of that anyway- we have a 67% Caesarean rate and everyone else has epidurals”
- As you care for her during labour, “I am frightened of dying during birth. Will I die? Can you please make sure I don’t die? I can’t let go because if I do I know I will die”.

What do you do with this? Another beginning...

On the other hand, if I ask a woman, “What was your labour like?” and she tells me “The contractions began at 3 o’clock and they were coming every ten minutes and lasting about 30 seconds, and they weren’t coming fast or strong enough. I dilated very slowly and didn’t progress so I had the drip to stimulate contractions, and I couldn’t cope then”. What does that tell me? Does it give me any hint as to what actually happened, or what it was like for her to be labouring? Does it tell me anything about the care she received?

Another beginning - I need to go further with this. “Do you know how the baby was lying – what position was it in?” She might tell me that she did not know what position the baby was in but she had backache all the time. Aha! “What were your contractions like?” and so on it goes.

Or another - If I asked “What sensations/feeling did you have/what was happening during the labour when you felt you couldn’t cope?” it might open up a wealth of information that could be very useful to me in our discussion about her forthcoming labour. She might tell me that in her labour she felt like she was in a dark labyrinth that led to an abyss so deep, she couldn’t let herself go there in case she couldn’t find her way out.

Or she may tell me as one woman did that in labour, every time she tried to step forward and go to wherever it was she was supposed to go, she looked across her shoulder and into death’s face. She realised that although she was brushing shoulders with death, it walked beside her and came no closer. She told me that when she made this connection, she moved forward with her labour and gave birth to her baby. She felt a connectedness with death, but knew she was not going to die. She described then that she felt that death was closely aligned with birth, not in the sense that birth was risky, but that birth along with death were life’s ultimate yet polarised realisations.

The encompassing beginning is about reframing our linguistic practices through analysis of discourse and interactions so that the tenets steeped in the culturally defined context that is obstetric and midwifery care enable mutual understanding between patients and healthcare providers. Or translated – inquiring and talking another way, so that women are able to share their experiences with us in their own terms, enabling us to see it another way. It really does make a difference.

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