

I have just finished reading a superb book; "The Tyranny of Numbers" by economist David Boyle (2001). In it, he critiques our society's reliance on and obsession with numbers and data, concluding that the really important things in life can't be measured. We have some really useless statistics as a result of our obsession – for instance, did you know that the average person will accidentally eat eight spiders during their lifetime while they are sleeping? Or that, in 1997, 39 people in the UK went to an accident and emergency department following an accident involving a tea cosy? However, because things like love, intuition, creativity, happiness and imagination are unmeasurable, they are given less importance by those making policy decisions; sometimes ignored completely.

How true is this in midwifery as well? We measure the length of a woman's labour (by our definitions) and deny her experience of the twenty hours she spent in early labour at home. We chart the physical progress of labour on a partogram but cannot see from this record any psychosocial or environmental factors that may have slowed things down. We can see from the birth record whether a woman had an episiotomy, epidural or a managed third stage, but have no clue from this whether she was happy with her experience or feels fulfilled as a woman and a mother. I worked in one hospital where the computer system required me to count and enter the number of antenatal visits the woman attended, but didn't care to know how many professionals were in the room when she gave birth. I would think that the latter had the potential for greater impact on the woman's experience of her birth.

Our decisions are often guided more by calendars and clocks than by the woman's own knowledge about her body. Several years ago, I heard a midwife speak about her experience of working in Africa. The women she worked with did not have a due date; they had a due season. Brenda Saunders (2002) writes that, in her experience in Zimbabwe, appointment times are not given to women, nor would they be kept. Women simply turn

up on a certain day or during a given week. While models of drop-in services have been set up in the UK, this would be an unthinkable situation in many units. Imagine saying to a woman, "Your baby will probably come sometime in November; if it gets to December and you decide you want to have your labour induced just come to labour ward anytime you're ready and we'll find you a midwife." In some units, staff find it difficult to cope when women turn up on labour ward without calling ahead so they can get "the notes"! We need to organise systems of care because we work in a bureaucracy, yet by definition systems based on numbers are not going to be good at meeting the needs of individuals.

This is not to say that numbers are always "bad". It is incredibly useful to know some things numerically. The normal range of haemoglobin levels in pregnant women is a useful set of numbers to know (as long as these numbers do refer to pregnant women, and not non-pregnant women). I like being able to give women numbers which help them make decisions; the percentage of women who give birth successfully at home, the number of women who end up having a caesarean section in a particular hospital, the number of babies who survive when born prematurely at a particular gestation. But, in each case, women also need to know that numbers are fallible; they are not guarantees, and behind each individual number lies a woman, a baby and a family.

So many aspects of the birth experience itself are human, subjective and personal. Our inability to measure pain or satisfaction on any kind of objective level means it is difficult to research these things quantitatively. This is compounded by the fact that our society sees safety as the most important factor; a factor which we seek to measure in numbers. Simply recording the numbers doesn't tell us anything about causality; that requires a leap of intuition by researchers before a theory is developed which can be tested.

At the National Sentinel Caesarean Section Audit study day, Mo Harris' work highlighted

the fact that it is possible to have a system of one-to-one care on paper, while in reality the midwives providing that service might not be providing the continuous support to women which that term implies. If the numbers sometimes lie, we need to find ways of getting around them. It is vital to look at the individual needs and experience of the woman, in real terms – yet how can we do that without always involving numbers, which can cause confusion and blur the issues? We do have some excellent qualitative research studies carried out with small groups of women, but these are then criticised for not telling us anything about the population as a whole. Rarely do their results have a direct impact on practice and on the experience of women.

Boyle (2001: 150) concludes that, “Measuring is easy these days. But the world is too

complicated for figures.” I would argue that childbirth is too. Unless we begin to focus on the way we can better understand evidence, knowledge and experience which does not fall into the numerically ‘measurable’ category, we will continue to live in a world where it is possible to calculate the number of spiders or tea cosies the average woman encounters during her labour without having any clue whether they have any impact on her experience of birth.

References

D Boyle (2001) *The Tyranny of Numbers*
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B Saunders (2002) What it’s like to work in Zimbabwe. *Practising Midwife*, 5(3); 36-39.