Tensions at the Theory/Practice Interface for Student Midwives

The Medicalisation of Childbirth

Medicalisation of Childbirth

- History: Faulty female bodies; Obstetrics v Midwifery
- Referral patterns as example of medicalisation
- Increasing intervention rates
- Institutionalisation of birth: control and surveillance
- Models of Childbirth
- Risk Discourse v Normal Birth
- Women's Choice?
- Evidence Base of Normal Birth
- Birthplace study
- Labour Suite Midwives
- Waterbirth

Medicalisation: Failing/Faulty/Leaky Bodies

- Original Grey's Anatomy privileged male body; female body invisible apart from gynaecology/obstetrics
- Female madness: hystero, need to be controlled and kept under surveillance
- Faulty bodies: episiotomy, induction/augmentation, hospitalisation of birth, proliferation of risk factors
- Reductionist history in obstetrics: powers, passages, passenger, disembodied
- Leaky bodies: douches, confinement, uniforms, segregation

Evidence of Medicalisation 20th Century: Referrals Patterns in Holland 1958 and 2003

1958	2003
Reasons to refer: 39	Reasons to refer: 143
Obstetrician needed: 24%	Obstetrician needed: 59%

Reasons

- Women with more risks having babies?
- Better screening and surveillance?
- Better treatments?
- Service more risk adverse?
- Loss of confidence in birth physiology?
- Midwives sphere of practice shrinking?

Has mortality and morbidity reduced?
Is there a trade off with iatrogenesis?

Risk Factors as Predictor of Outcome

- Risks identified by population studies
- Not accurate predictor for individual woman
- Care pathways need flexibility

Denis Walsh, Nottingham University

Medicalisation of Childbirth

- Increasing CS rate: 15% to 24% (1990 – 2010)
- Falling normal birth rate: 60% to 48% (1990 – 2005)
- Increasing Epidural rate: 17% to 34% (1980 – 2010)
- Increase in women with complex medical/obsteric history
- Fewer women classified as low risk, more risk factors identified

Medicalisation of Birth

- Low risk Nullips Australia: 44% augmentation, 46% epidural, 57% NSB (Tracey et al, 2007)
- More intervention in private v public maternity care (Dahlan et al, 2012)
- Maternity Care Working Party for Defining Normal Birth i.e. physiological labour & birth
- target of 60% normal labour and birth by 2011 (Werkmeister et al, 2008)
- Has not been achieved in most UK maternity services

Centralisation of Birthing Services

- Larger and larger maternity hospitals
  - Up to 10,000 birth/year
- Home births rates very low at 2%
- More obstetricians, neonatologists, more obstetric anaesthetists
- More subspecialisation and tertiary referral units

Beliefs About Labour & Birth

Social Model v Medical Model

- **Whole person- physiology, psychosocial, spiritual**
- **Respect and empower**
- **Relational/subjective**

- **Environment central**
- **Anticipate normality**
- **Art**
- **Local/community**
- **Technology as servant**
- **Celebrate difference**
- **Trust**
- **Intuition/meaning-making**
- **Connection**
- **Self actualisation**

- **Reductionism – powers, passages, passenger**
- **Control and manage**
- **Expertise/objective**
- **Environment peripheral**
- **Anticipate pathology**
- **Science**
- **Centralised institution**
- **Technology as partner**
- **Homogenisation**
- **Risk**
- **Guidelines/objective facts**
- **Separation**
- **Safety**

(Mackenzie et al, 2010)

Revisiting Anthropological Dimensions of Childbirth

- women as creators
- oneness between mother & baby
- power, beauty, strength of woman's body in birth
- mother's intuitive knowledge of herself & her baby
- sense of mystery around birth
- rites of passage experience
- as transformative & opportunity for personal growth
- symbolised by love, not fear

(Davis-Floyd, 1997)

Risk Discourse in Childbirth

- Normality defined by abnormality
- Environmental Effects
- Presenting risk information
- Super-valueing of Technology
- Complaints & Litigation

Defining Normal Childbirth (Scamell & Alaszewski, 2012)

- By reference to abnormality: not induced, no C/S, no AVB, no epidural, no episiotomy
- By reference to an absence of risk
- Such an orientation focuses on potential risks without mentioning the low probability of their occurrence
- So in waterbirth chance of the baby drowning is considered a risk but no mention of the extremely low probability of that occurring
- Worse case scenario thinking

Focus on Normal Birth

- Consistent Government policy since 1993
- More research on benefits of midwife led care
  - Systematic review of midwife led care (Hatem et al, 2008)
  - Systematic review of alternative birth settings (Hodnett et al, 2009)
- Consistent government policy on choice of place of birth
  - Increasing no's of midwifery units both free-standing and alongside
- Increase in markers of physiological birth: more upright birth, more physiological 3rd stage, fewer episiotomies, more water immersion and waterbirth

Midwife Relationships

- With women
  - informal, personal, reciprocal
  - facilitator, enabler, empowerer
  - partnership, advocacy
  - connectedness, trust
- With obstetricians
  - equality
  - collegiate
  - collaborative
  - mutual respect
  - non-hierarchical

WHAT WOMAN WANT

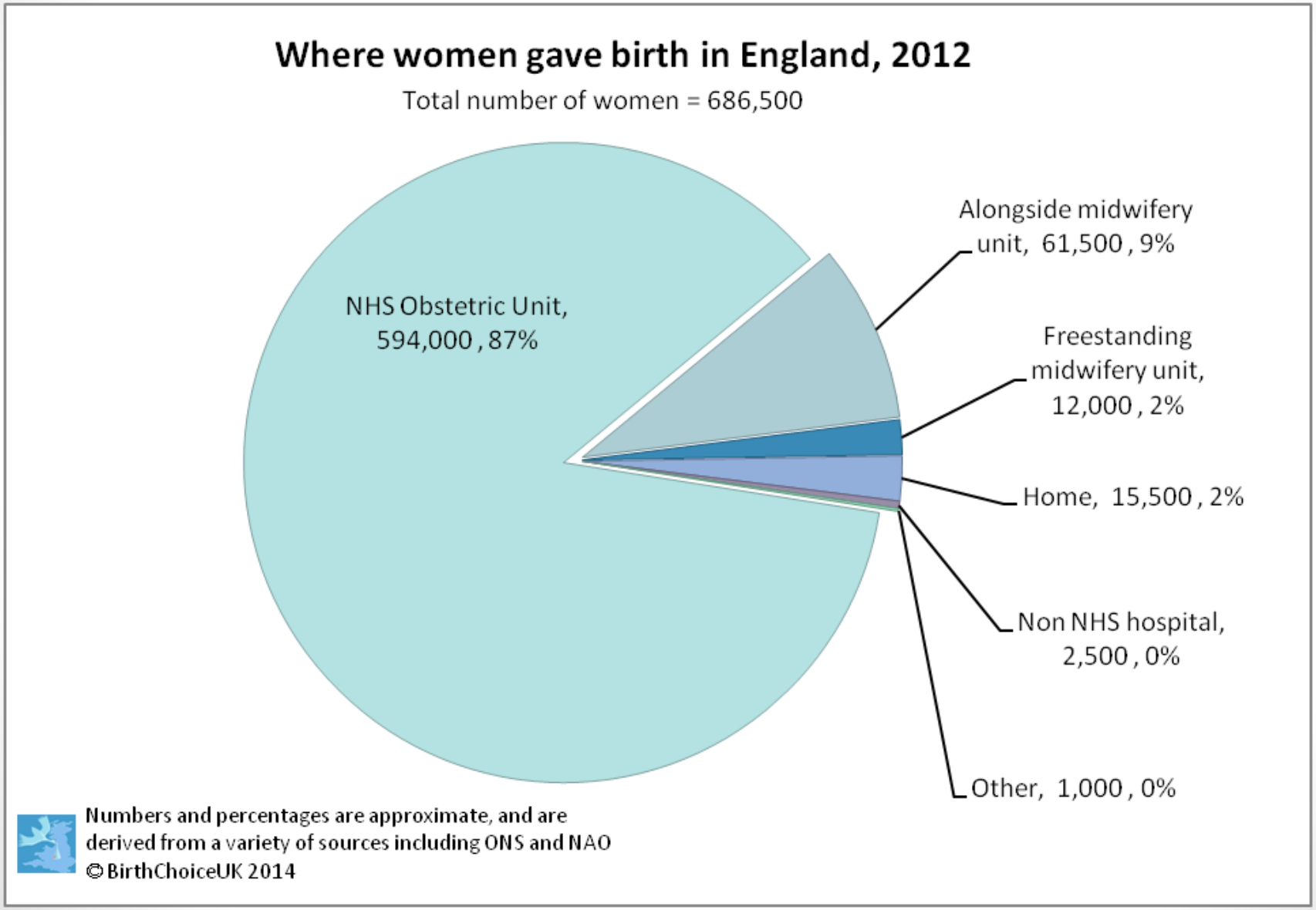
- Information (DH, 2007)
  - full
  - accurate
  - evidence-based
  - individualised
- Choice (Kirkham, 2004)
- Control (Green, 1999)
- Continuity (Hodnett, 2009)
- Compassionate/kind care
- Expectations (Green et al, 1998)

Cochrane Reviews Relevant to Physiological Birth

- Alternative birth environments (Hodnett et al, 2013)
- Midwife-led care (Sandell et al, 2013)
- Continuous support in labour (Hodnett et al, 2008)
- Movement in labour (Lawrence et al, 2009)
- Upright posture for birth (Gupta & Nikodem, 2006)
- Water immersion (Cluett et al, 2009)
- Acupuncture/hypnosis for labour (Smythe et al, 2009)
- Partograms (Lavender et al, 2013)
- Delayed cord clamping (McDonald & Middleton, 2008)

Birthplace Study

- 65,000 low risk women in England
- OU = Obstetric Unit
- AMU = Alongside Midwifery Unit
- FMU = Freestanding Midwifery Unit


Where women gave birth in England, 2012
Total number of women = 686,500
NHS Obstetric Unit, 594,000 , 87%
Alongside midwifery unit, 61,500 , 9%
Freestanding midwifery unit, 12,000 , 2%
Home, 15,500 , 2%
Non NHS hospital, 2,500 , 0%
Other, 1,000 , 0%
Numbers and percentages are approximate, and are derived from a variety of sources including ONS and NAO
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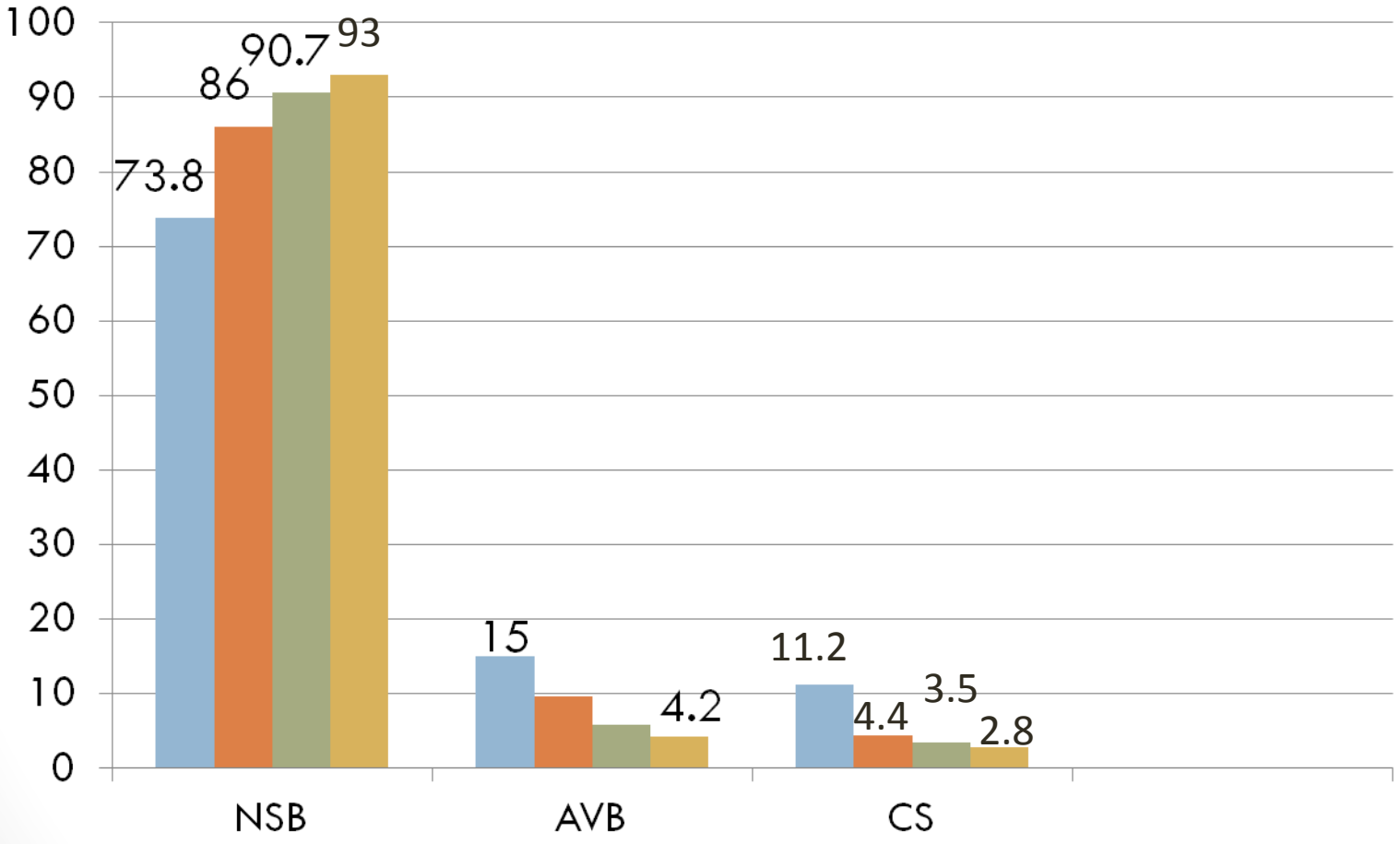
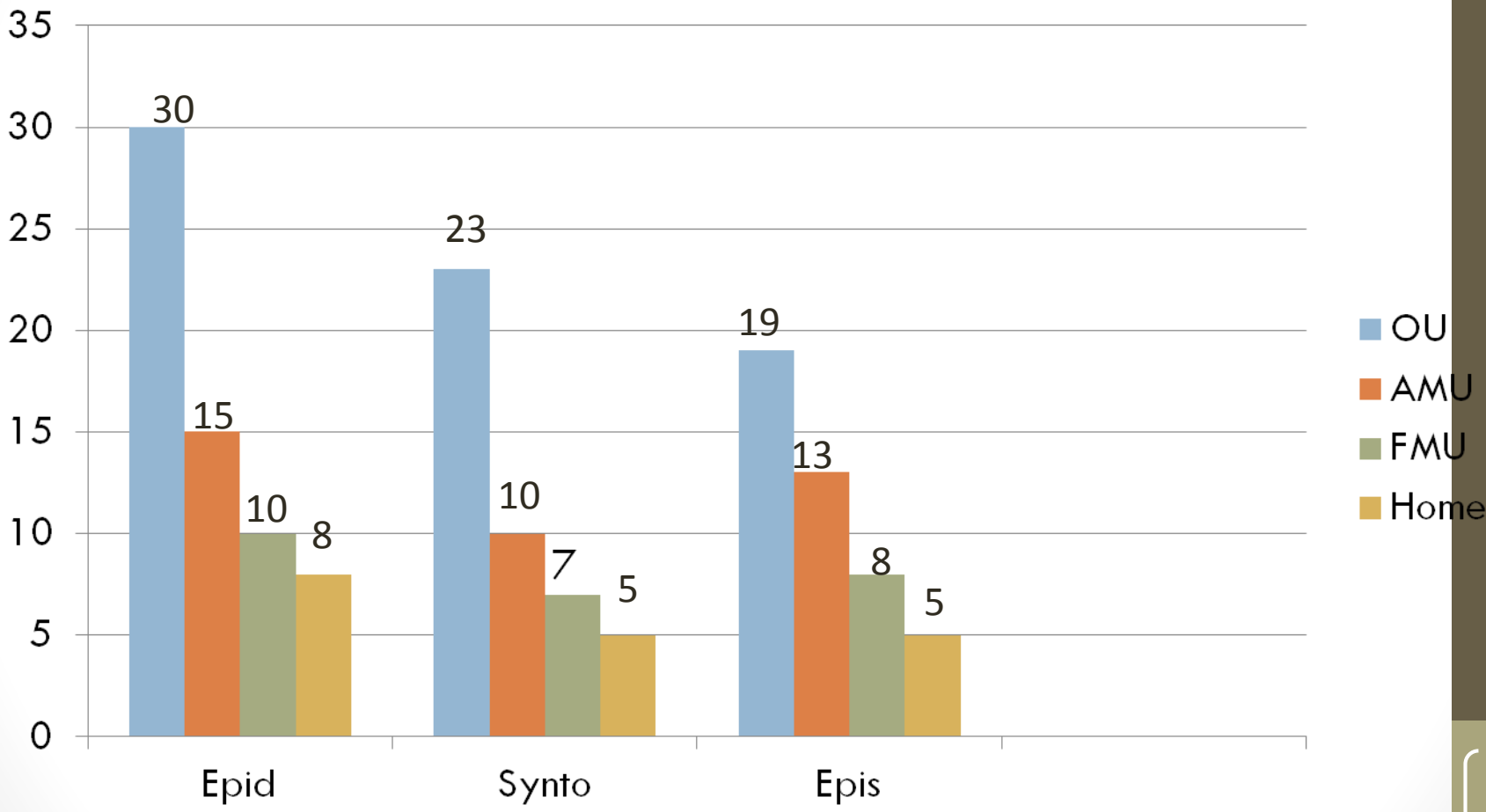
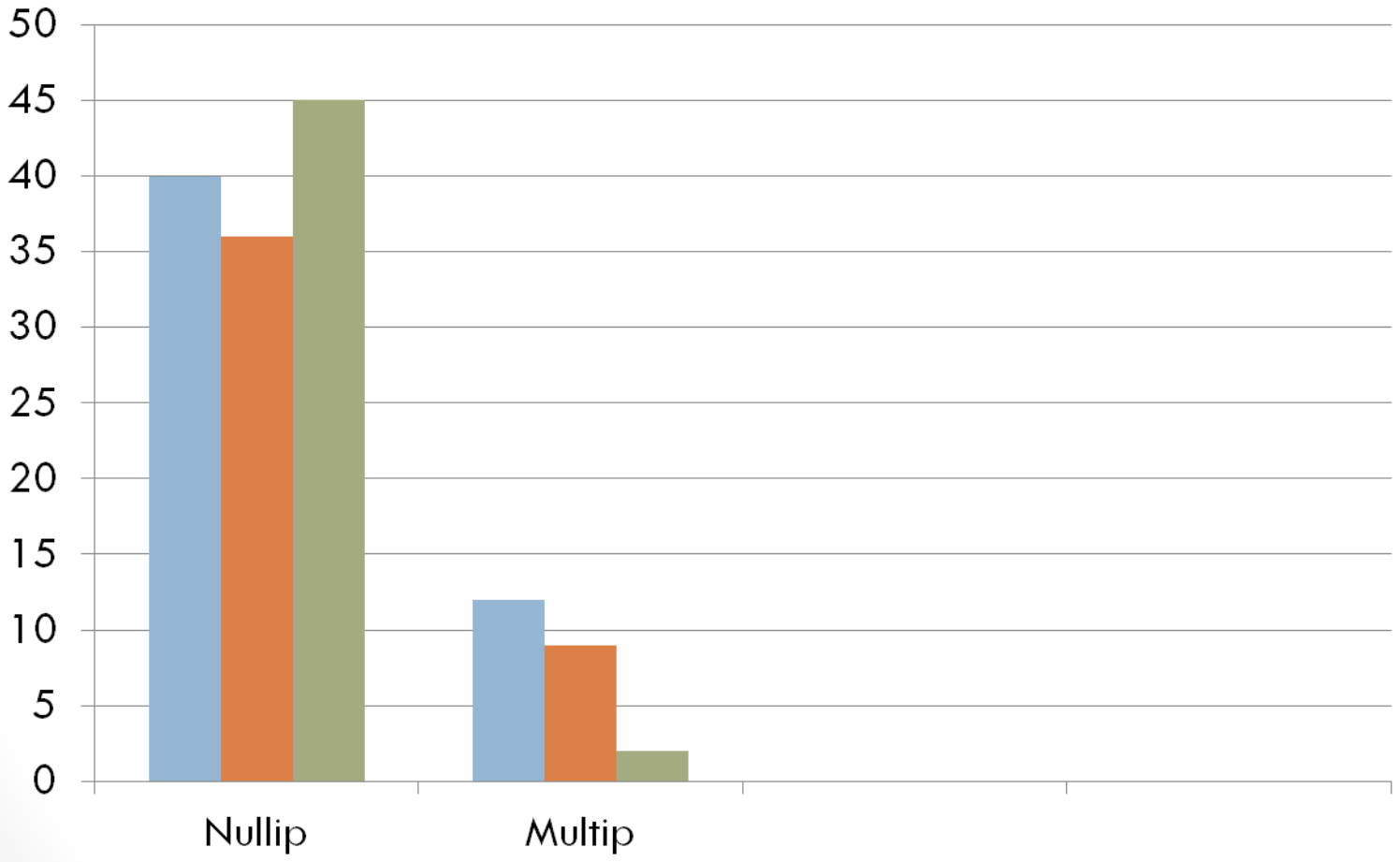
Type of Birth by Place



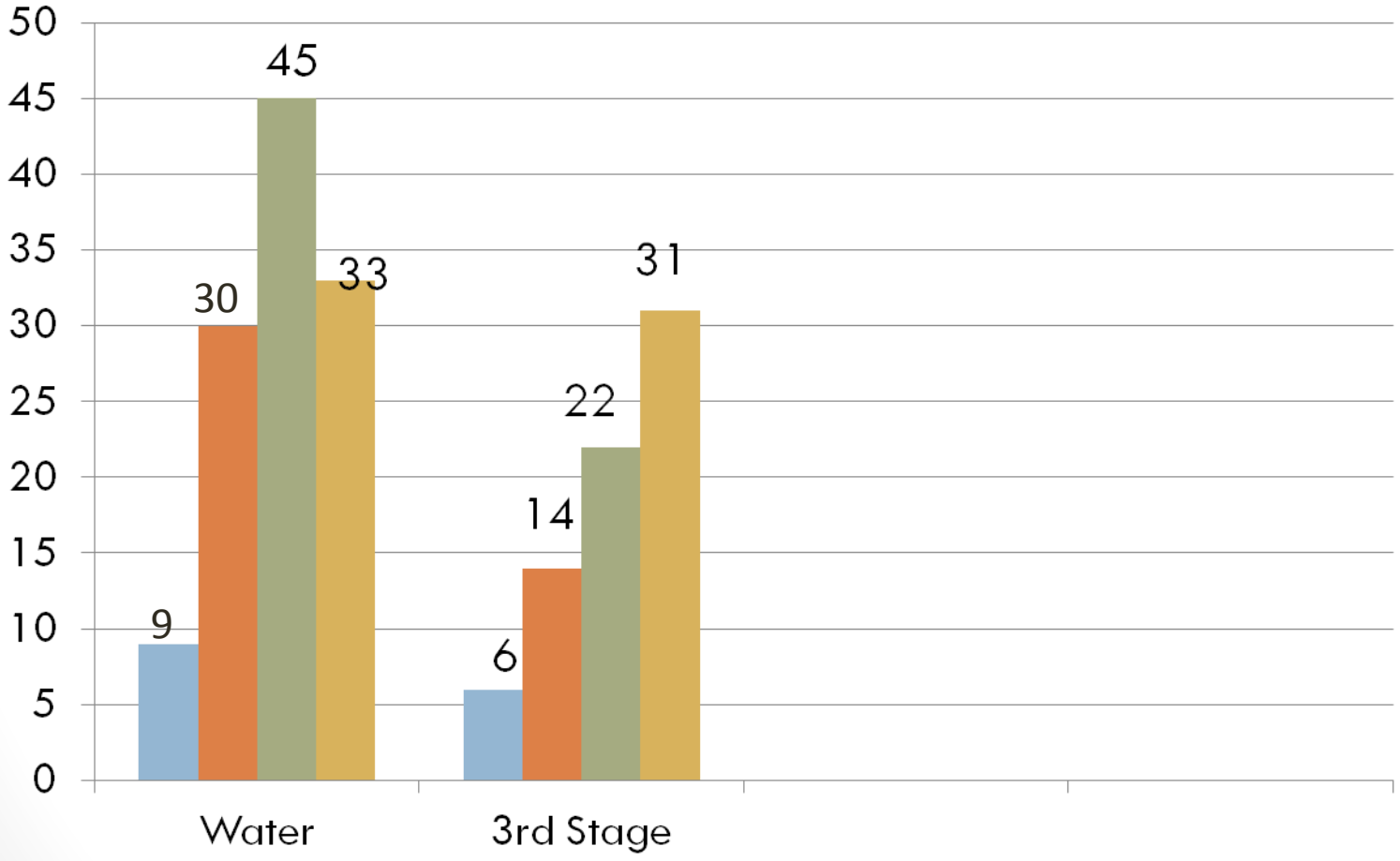
Epidural, Augmentation, Episiotomy by Place of Birth



Intrapartum Transfers



Water Immersion & Physiological 3rd Stage



Take Home Messages BirthPlace Study

- OU, AMU, FMU and home are very safe for babies
- Perinatal outcome for nullip, homebirth women is not as good as nullip OU, AMU and FMU women (9.3 v 5.3/1000)
- Home, FMU, AMU lower C/S rates
- Home, FMU, AMU lower intervention rates
- Transfer rates for nullips are around 40% from home, FMU's, AMU's
- Intrapartum costs: home was much cheaper than FMU, AMU, OU

Take Home Messages BirthPlace Study

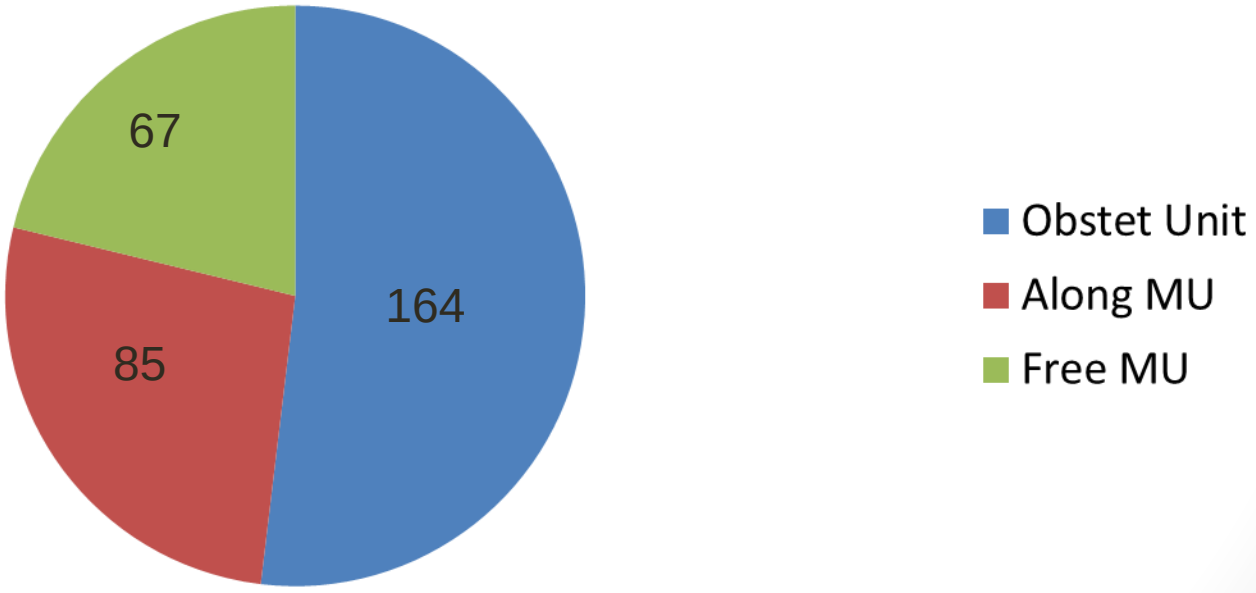
- every maternity service should provide AMU's and FMU's as part of a set of choices for place of birth that should also include home birth

Pathways for Low & Higher Risk Women

- Start with 100 women (100%)
- Percentage of all women at higher risk at booking: **40% (40 women)**
- Percentage low risk women transferred to obstetric care during pregnancy: 25% (15 extra women now high risk at onset of labour)
- **Therefore 55/100 higher risk at onset of labour**
- Percentage of low risk transferred to obstetric care during labour: 25% (11 women)
- **66/100 women (66%) birth in obstetric units**

Type of Maternity Units England 2013 (NAO, 2013)

Actual: Midwifery Units: 11% of all birth
Obstetric Units: 87% of all birth
Ideal: Midwifery Units: 33% of all birth
Obstetric Units: 67% of all birth



Role of Midwife on Mixed Dependency Labour Suite

1. Midwife/Obstetric Nurse
   - Follow protocols
   - Carry out obstetricians instruction/directions
   - Kind, caring, empathic
2. Midwife committed to normalising labour & birth wherever and whenever possible
   - Looks for every and any opportunity to maximise physiology, within constraints of technologies and drugs
   - Dialogues with obstetrician as to care plan
   - Kind, caring, empathic

Role of Midwife on Mixed Dependency Labour Suite

3. Midwife as advocate/champion of normal birth
   - Challenges policies and guidelines on behalf of individual woman e.g. waterbirth VBAC, active upright, vaginal breech
   - Looks for every and any opportunity to maximise physiology, within constraints of technologies and drugs
   - Dialogues with obstetrician as to care plan
   - Kind, caring, empathic

Labour Ward Coordinators Role

- UK Labour ward midwives 'obedient behavior':
  - an obligation to follow hospital policies
  - fear of consequences from challenging senior staff

  (Hollins & Bull, 2006)
- Ireland Feminist critique of labour ward: 4 concepts of patriarchy
  - Hierarchical thinking
  - Either/or dualistic thinking
  - Logic of domination
  - Power and prestige
- Negotiating between normality and risk: the Swan Effect (Scamell, 2011)
- Developing a toleration for uncertainty (Page & Mander, 2013)

Coordinators Role in Developing Practice on Labour Wards

- To be first to learn new skills/therapies
- To normalise birth as far as possible given interventions/drugs that are required
- To optimise the potential for normality in a labour that commences normally but becomes a situation of uncertainty
- To distinguish between the above group and those who need timely referral to obstetrics
- To help develop midwives as autonomous practitioners, to have confidence in their decision-making

Water Immersion/Birth

- Calm birth environment
  - Reduces traffic through birth room (protects privacy)
- Can speed up labour in nullips: prevent and treat dystocia
- Reduces need for epidural, narcotics
- More intact perineums
- Hands off technique
  - may contribute to better perineal outcomes
  - Empowering for women who birth baby themselves unassisted
- Physiological third stage with benefits of intact cord
- Maximises movement and upright posture
  - Optimises oxygenation to baby (avoids supine hypotension syndrome)
  - May reduce incidence of posterior position
- Emphasises ‘being’ rather than ‘doing’ disposition of midwife