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 20\textsuperscript{th} Century: Referrals Patterns in Holland 1958 and 2003

<table>
<thead>
<tr>
<th></th>
<th>1958</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons to refer:</td>
<td>39</td>
<td>143</td>
</tr>
<tr>
<td>Obstetrician needed:</td>
<td>24%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Denis Walsh, Nottingham University
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
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/obstetric 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

Social 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

Medical Model:
- 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. © BirthChoiceUK 2014
Type of Birth by Place
Epidural, Augmentation, Episiotomy by Place of Birth

Nottingham University
Intrapartum Transfers

- Nullip
- Multip

Categories:
- AMU
- FMU
- Home
Water Immersion & Physiological 3rd Stage

![Bar Chart]

- **Water**
  - OU: 9
  - AMU: 30
  - FMU: 45
  - Home: 33

- **3rd Stage**
  - OU: 6
  - AMU: 14
  - FMU: 22
  - Home: 31
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

- Obstet Unit: 164
- Along MU: 85
- Free MU: 67
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