AIMS For a better birth...

Midwifery Today Conference - Keeping Birth Normal

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A wide range of topics were covered over the course of this four day conference, including herbal medicine, anthropology of birth, birth counselling, normalising breech birth, the politics of midwifery, communication, nutrition, setting up a home birth practice, independent midwifery, dealing with complications during labour and birth, technology, physiology, midwifery education, waterbirth, VBAC, breastfeeding and the newborn. As many sessions took place concurrently, this report only covers the limited number I attended.

In her address "*With Women*" or *With the Powers' That Be*, Mavis Kirkham, Professor of Midwifery in Sheffield, England asked whether midwives are fulfilling their traditional role of being "with women" or are they becoming "medwives" and practising in step with current medical fallacy. Using her own research on supervision in midwifery, she examined the midwifery culture of service and sacrifice and the paradox of attempting to move to woman-centred care without recognising that midwives need to be supported and cared for as well.

During the interviews she carried out with midwives, they frequently used the word 'selfish' in relation to their own needs, and only expressed needs privately during confidential interviews. These midwives often intemalised guilt and blame, felt the need to conform to cultural norms, lived in a world of fear, fell back on 'doing good by stealth' and avoided conflict - none of which are conducive to caring for women, being appropriate role models for women or developing midwifery practice through sharing knowledge and open discussion. An oppressive nunagement system disempowers both midwives and women.

Perhaps one of the paradoxes of greatest concern, is that *safe and empowering birth outcomes hinge on trust between woman and midwife*. Women are expected to trust midwives, who are themselves victims of a culture of blame within their supervisory structure. One of the fundamental changes necesary is the acknowledgement that in order to care for women, midwives need to care for each other.

Mavis also suggested that *professionalisation undermines the midwife's ability to be "with women", but that continuity provides a mechanism for breaking down barriers and professional blinkers*, enabling midwives to be with women. Indeed this seemed to be one of the clearest messages throughout the conference, both in the talks and in the informal discussions. Many midwives from different cultures described in many different ways that the heart of midwifery lies in the relationship of trust between women and midwives.

Michel Odent is a former obstetrician best know for his work at Pithiviers and founder of the Primal Health Research Centre in London. His address, *Physiological Birth is Normal Birth* began with the premise that whilst "normal" is a culturally defined concept, physiology is a more universal point. He suggested that we need to be aware of when we are deviating from normal physiology, keeping this to the minimum possible, and always maintaining it as reference.

He then described factors, which arise from stimulation of the neo-cortex in the brain, which inhibit the birth process.

Michel believes that in order to support physiological processes during labour and birth a woman needs to enter a trance-like state. The neo-cortex is stimulated by words, especially rationalising, so asking the woman questions during labour is particularly inhibiting - silence and very simple words should be used. Bright lights and the feeling of being observed slimulate the neo-cortex in the same way. Similarly, any situation that causes the mother to produce adrenaline interferes with the labouring process.

He went on to suggest that we need a clear concept of the perinatal period and awareness that hormonal changes in both the mother and child continue after birth. Whilst this is a complicated field, he described a few of the hormones involved during this period along with some of their effects on the relationship between woman and baby. The release of oxytocin ("the hormone of love") for example is potentially at its highest immediately after birth if the women is enabled to look at and feel her baby skin to skin in a warm room. There is a high release of prolactin which is known as the hormone of motherhood, and endorphines produced after birth promote deeper attachment between the mother and her baby.

In conclusion all hormones have a crucial role to play during labour and birth and in the interactions between the mother and baby, many of our routine practices disturb these sensitive physiological processes (we page 8 for more).

Mavis Kirkham appeared again with Nancy Wainer Cohen (childbirth educator, midwife and author of *Silent Knife* and *Open Season*) to talk about *Midwives' Role in Protecting Birth*. One of the resources midwives have, they counselled, is the ability to move between head and heart. The stories told by speakers and delegates alike highlighted how knowledge can be from many different sources. Whilst research i.s a part of this, midwives and women's stories can inform us qualitatively. Bringing the two together can be particularly enriching and begin to shape a woman and midwife-centred body of knowledge and research agenda. Both Mavis and Nancy had stories that give meaning to billh and the role of the midwife, in a poignant and vital way.

Mavis suggested that *we need to have faith in birth and in women, and that this needs to explicitly expressed, in order to reverse the cultural undermining of confidence in birth and women.*For example, women's birth stories could play a crucial part in fostering positive attitudes through antenatal education but there are often attempts to 'protect' women from these.

She went on to look at the role of the midwife in conveying faith in the woman's ability to give birth - being there and doing nothing gives a message of normality, that labour is copable with, and that the woman is indeed coping. She told us about accompanying a midwife in the community some years ago. She noticed the midwife knitting during women's labours and asked what she was knitting. It transpired that the midwife was not a knitter and was not knitting anything in particular, but that knitting in a corner of the room allowed her to be with the woman, without observing her, but letting her presence reassure the woman that all was well. The midwife had carefully selected knitting needles that would give just the right barely audible sound, so as not to distract the woman, but continue to let her know she was there.

In hospital settings, Mavis suggested simple mechanisms for keeping the system at bay, shutting the door, putting up 'do not disturb' notices, but also moving away from an institutionalisation mindset by using simple questions suggested by independent midwife, Alice Coyle - 'is the mother okay?, is the baby okay?, is the midwife okay?'.

She also suggested that part of the midwife's role is to protect women's birth stories, by helping women to shape them into tales of bravery which can strengthen and empower, rather than tales of weakness and humiliation which undermine and disempower.

Nancy also addressed the issues of inappropriate language around birth, which disempowers women and moves the focus onto attendants rather than the woman herself. Midwives and doctors often talk about 'delivering' babies when it is women who give birth and helpers who asist or attend her, or the birth.

Jean Robinson, Visiting Professor at Ulster University, long-standing researcher, lecturer and writer on consumer issues and Hon Research Officer for *AIMS* gave a stimulating address on T*echnological Threats to Normal Birth* focusing on ultrasound, which includes the use of dopplers, sonicaids and electronic fetal heart monitoring. Jean not only has the ability to render the potentially dry and difficult subject or examining research, interesting, even exciting, but inspires the belief that women and midwives have a great deal to contribute to this process and to reshaping the research agenda.

She gave an example of a piece of research carried out in Glasgow in 1974, on 200 women and babies to show whether or not induction reduced the stillbirth rate in mature babies. When she looked at the overall stillbirth rate in this
group of babies, she found it to be 3 per 1000. She suggested that one would not have to be a mathematician to work out that the research could not possibly tell us anything!

A further problem with a medicalised research agenda, is its tendency to the body as a machine and the process of birth as a mechanistic sequence of events. Thus when researchers wanted to discover the

mechanism for the demonstrated beneficial effec&s of a companion in labour, they allocated hospital cleaning staff to unsupported women arriving at a hospital in labour, for a period of one hour.

Jean went on to talk about ultrasound, suggesting that it is a difficult issue to challenge because women do not dislike it. Nevertheless she outlined her main concerns as follows:

- ultrasound can be used by professionals who have little or no training in its use
- in terms of dating, ultrasound can be inaccurate
- using ultrasound engenders confidence in machinery rather than women
- the woman becomes a transparent vessel, whose main role becomes one of compliance
- research on increased bonding is poor
- when abnormalities are detected, there is a tendency to aggresively influence women towards termination
- whilst scans are used for reassurance especially on women who have had previous losses in pregnancy, there is no treatment for a baby who is going to die
- we do not know the effect of wrong diagnosis on women and parents

There is little hard data, but research suggests that ultrasound may be causing subtle neurological changes which can affect speech, hearing and thought patterns. Other research suggests that miscarriage and pre-term labour may be increased by the routine use of ultrasound tests, but these issues have not been rewarched in their own right. So far these studies have been discredited rather than used as a basis for further study.

Animal studies show that ultrasound affects growth, and research on humans suggests similar patterns though the mechanism for this is unknown. Jean suggested we could be considering the effects of overheating or cavitation as possible explanations. To date there has been little debate about these possibilities. It is also possible that just as electronic fetal heart monitoring was introduced to detect adverse changes in fetal heart rates, and
subsequently discovered to cause these, ultrasound, used to detect problems in
growth may causing growth problems. In addition, research on the use of ultrasound to detect abdominal wall defects in unborn babies showed better outcomes in the unscanned babies when these were not detected.

In the past, the effect of ultrasound was weakened and the baby more protected by the woman's belly and fluids in the body. The relatively new transvaginal probe brings ultrasound much closer to the developing baby and the effects of this remain unknown.

Of particular concern at present is that the research to date is being rapidly
outdated by the ever increasing output of ultrasound scanners. Whilst we are unclear about the effects of older machinery using a lower output, we have no idea what effect increasing the output may be.

One of a number of round table sessions included Robbie Davis-Floyd (Research Fellow in the Department of Anthropology at the University of Texas and author) Jan Tritten (editor of MIDWIFERY

TODAY and BIRTHKIT), midwife and one of the main organisers of conference, Ina May Gaskin (founder of The Farm Midwifery Center in Tennessee, editor of the BIRTH GAZETTE, author and President of the Midwives Alliance of North America) Judy Edmunds (independent midwife, nutritional consultant, herbalist and massage therapist in the States) and Suzanne Arms (photojournalist and author of seven books related to childbirth). Each participant addressed the topic of *Birth Change Agent* and explored ways we can all promote positive birth change and gave examples of how they and others had introduced change or are attempting to introduce it. These included:

- "courting" a practitioner considered to be preventing change
- cross-cultural fertilisation to explore cultural norms
- networking through the Internet
- creating and disseminating positive stories about childbirth
- involving and educating the woman's family numbers during pregnancy
- incorporating sensuality as part of the birthing
- rewriting medical textbooks
- politicising midwifery education
- liaising with those in high places who are sympathetic to midwifery
- identifying successes elsewhere and adjusting for other cultures
- using humour as Ina May Gaskin did in her efforts to the attitude to breastfeeding. Ina May identified a 'mental illness' in America, preventing breastfeeding as 'nipple phobia'. The approach received wide coverage.
- using both individual and collective approaches

Finally, Robbie Davis-Floyd described how representatives from childbirth education, doula and midwifery organisations and key individuals in North America formed the Coalition for Improving Maternity Services (CIMS) and, working by consensus, produced a position statement and 10 steps of the Mother-Friendly Childbirth Initiative for Mother-Friendly Hospitals, Birth Centers and Home Birth Services. The statement is evidence based and hospitals can apply to be designated mother-friendly.

Robbie, also addressed the issue of *Making Decisions in Childbirth and Midwifery: Whose Knowledge Counts?* By looking at the ways in which people think, exploring open and closed systems and authoritative knowledge, we may better be able to understand the medical model of childbirth and why and how to challenge it.

She described thought processes and different types of thinkers. Patterns develop in utero for making sense of the world and continue after birth as the human mind attempts to divide up all it meets into discrete categories. Information that fits easily is assimilated through pre-existing cognitive structures, but new information must be assimilated by creating new neuronal structures which requires time and energy - or can be ignored, or stored for potential further use.

Humans develop different ways of thinking and can be conveniently described as stage 1-4 thinkers. Stage 1 thinking portrays a rigid mind set, typically that of fundamentalists including technologists,

where only one world view is acknowledged. Stage 4 describes fluid thinkers, prepared to move between paradigms and remain open to new ideas, displaying an ability to be self aware and accept different forms of reality. To maintain stage 4 thinking poses stress on the system and if these thinkers revert to the narrow stage 1 thinking. The stressful socialisation of medical students tends to maintain a stage 1 unquestioning stance.

Robbie then went on to describe two models of childbirth, the technocratic model which likens the body to a machine and uses metaphors from the industrial model. Machines and technology are imbued with the ability to produce the child. The holistic model takes a more open and responsive approach to birth. Anyone interested in this topic should certainly read her book *Birth as an American Rite of Passage* where she explores the use of westernised birth rituals and their impact on women's lives.

There are the usual conference gripes - some sessions not matching the programme, a cold main conference room, long days, sometimes from 8am-10pm, but overall this was a good conference, more focused than last year, with well defined breaks throughout the days and a good combination of general and concurrent sessions with a reasonable theory/practice balance.

It is not always easy to bridge cultural differences in midwifery and childbirth philosophy and practice, and importing conferences can be problematic. Whilst the MIDWIFERY TODAY team continues to address this issue, there is still some fine tuning to be done in terms of increasing dialogue and understanding. Most importantly, however I left the conference feeling that there is a commitment to developing a body of midwifery knowledge, which is not anti-technology, but which has a range of creative solutions to be drawn on. I felt confident that there is indeed support for an approach to birth which considers the woman and birth as a whole and relies on trusting relationships between women and midwives as one of the main components of safe (in its widest sense) childbirth.

Nadine Edwards
Note: *The next conference in London will be beld at Ealing Town Hall again from 23 - 27 September 1999. Watch this space for booking details*