AIMS For a better birth...

Increasing home birth is vital

AIMS Journal, 2008, Vol 20 No 4

Denis Walsh looks at the future of maternity services in the UK

Midwives often use personal anecdotes to illustrate learning experiences and one that comes up more than most is their first experience of home birth. Fifty years ago this would have been less likely because home birth was the norm. Part of the reason that first experiences of home birth now make such an impression is that, against a backdrop of hospital and often medicalised birth, birth in this context is very novel and different. One of the striking differences is in the informality of the setting and the easy-going friendly rapport that exists between the midwife and the family. This setting is not replete with institutional 'dos' and 'don'ts' and conventions of care. I do regular clinical work in a large maternity hospital and there you are continually reminded of the 'rules'.

Recently, after a birth, an older sister wanted to visit her Mum and new baby sister only to be told that only two relatives (the father and younger sister already present) were allowed and it was not permissible to change. The rationale for this was security. Understandably, the family were perplexed by the decision. No such constraints apply at home where the professional is a guest. Another way to express this difference is that our common humanity is more obviously expressed in home birth and birth is an intensely human experience where often the full array of emotions are on show. As we head into the 21st century the hospitalisation of birth is altering fundamentally how birth has been done over millions of years.

I do not intend to ignore the advances in medicine that have made birth so much safer for women at high obstetric risk. These should be lauded but not traded off for the fundamental 'humanness' of birth. As we review maternity ser vices in the United Kingdom, the humanness of birth is being challenged by a number of discourses; what I mean by 'discourses' is 'regimes of truth' or orthodoxy that now shape and regulate maternity services in ways that can be dehumanising.

Dominant Discourses

Medicalisation

There is overwhelming evidence all over the world that normal, physiological birth is under threat. This is illustrated by rising caesarean section rates and of interventions like oxytocin augmentation and epidurals during labour. In the last few years the Depar tment of Health in England and Wales has recognised that it is not just birth outcomes that are medicalised, but labour as well, by including this in the national statistics. Last official figures put normal labour and birth (normal birth without routine

intervention) at 46%[1] and the Normal Birth Working Party set a target of 60% by 2010.[2] There are many reasons why we should be concerned about the trend to medicalisation, particularly the way that it can disempower women and rob them of the feeling of achievement.

Centralisation of birth

There is also a world-wide movement to centralise birth and this is particularly marked in the UK[3] It is caused by medicalisation and the power of professional groups added to the arguments for saving money by rationalisation.

Regional centres of excellence including neonatal, anaesthetic and fetal/maternal services are now government policy.[4] Centralising facilities produces economies of scale but there is a point where bigger means more expensive.[5] The mistake that is being made is to pool all normal birth with high risk birth in these centres. The effect of all of this is the tendency towards assembly-line birth which contrasts sharply with the 'small is beautiful' ethos of birth centres.[6] Birth becomes an event to be 'processed', rather than an experience through which women can be nurtured and supported.

Institutionalisation

One of the effects of this centralisation of birth in large hospitals is that the hospital is an institution with its own pressures and these pressures highly regulate people's behaviour, and tend to turn labour into a mechanical, measurable event.[7] Institutions also tend to set up the environment to serve the needs of professionals and technology, contrasting sharply with the ambience of home.[8] They are often bureaucratic and hierarchical, conforming the individual to a patient role and then setting up the professional as an authoritative voice.[9] Much of this undermines the vast amount of research that stresses the value of relationships in care for labour and birth.[10]

Risk

Individuals and institutions like hospitals are becoming increasingly risk adverse and these effects are powerfully felt in maternity services. Litigation feeds this perception. There is a paradox here as it has never been safer in the western world to have a baby.[11] The effects are a greater reliance on protocol rather than flexible care and judgement; birth becomes dominated by fear rather than love.

Techno-rationalist society

Within the traditional approach to childbirth we understand it as a rite of passage where pain is integral to the experience rather than something which must be relieved. Writers, including Lauritzen and Sachs, [12] have described our techno-rationalist society as one in which technology is 'super-valued' as the solution to illness and pain leading to the heavy use of epidurals and narcotics in current practice.

Impact on Midwives

All of these discourses affect midwives in powerful ways. We know this partly through the research on

why midwives stay in the profession13 and why they leave.14 Midwives leave because they are not able to practise autonomously, experience institutional bullying, develop burnout and all of these occur more frequently in large, medicalised hospitals. They stay where they feel valued, are able to practise normality and where there are opportunities to develop positive relationships with women users13 These conditions are more likely to exist in birth centres and in community practice.

Increasing Home birth

All of the above discourses would be addressed by increasing the home birth rate. The effects of medicalisation, centralisation of birth and institutionalisation would be reduced. We know that home birth results in fewer labour interventions and high degree of maternal satisfaction.15 Shifting the perception of risk is more challenging and is one of the reasons why many women are reluctant to consider home birth. Community midwives need to be key advocates as they shape women's choices quite profoundly.16 Learning from 'hot spots' of current high home birth rates in England and Wales is a good place to start to challenge the notion of risk.

A radical overhaul of attitudes to pain in labour is required to challenge the techno-rationalist paradigm. A key area for this is antenatal education, especially the Preparation for Childbirth Classes. Home birth mothers should help lead sessions on place of birth choice; class leaders need to facilitate discussion on a 'Working with Pain' approach, engaging with the idea that birth can be empowering and an opportunity for growth, as opposed to the 'Pain Relief' approach.7 Finally midwives need much greater exposure to home birth. This could start during the student midwifery training: the Midwives Association of North America (MANA) require students on their programme to attend a minimum of 10 out-of-hospital births and a similar target should be set here in the UK and all midwives involved with labour and birth should be required to attend one home birth a year. I know these may appear unrealistic targets but unless home birth opportunities are maximised, the status quo will not be challenged.

Conclusion

The problems in the maternity ser vices are not just about a clinical imperative around risk, medicalisation and centralisation of birth but an accompanying institutionalisation that limits the expression of humane attributes of birth. In other words, there is a humanitarian imperative that is currently being neglected, with women and professionals both suffering. A concerted effort to rehabilitate home birth as a mainstream option for women at low obstetric risk is urgently needed. This is one of the key ways that the dominant discourses, impinging on birth, in the UK, in the 21st century, can be challenged and that a more humane, enabling alternative can be promoted.

References

1. The Information Centre (2007) NHS maternity statistics, England: 2005-6
2. Normal Birth Consensus Group (NBCG) (2008) Making Normal Birth a Reality.
3. Walsh D (2006a) Improving Maternity Service. Small is Beautiful: Lessons for Maternity Services from a Birth Centre. Oxford: Radcliffe Publishing

4. Shribman S (2007) Making it Better : For Mother and Baby. Clinical Case for change. Report by Sheila Shribman, National Clinical Director of Children, Young People and Maternity Services
5. Posnett, J (1999) The hospital of the future: Is bigger better. Concentration in the provision of secondary care British Medical Journal, 319;1063-1065
6. Walsh D (2006b) Subverting assembly-line birth: Childbirth in a free-standing birth centre. Social Science & Medicine, 62(6):1330-1340
7. Walsh D (2007) Evidence-Based Care for Normal Labour & Birth: A Guide for Midwives. London: Routledge
8. Fannon, M. 2003. Domesticating birth in the hospital: 'Family-centred' birth and the emergence of 'homelike' birthing rooms. Antipode, 35(3):513-35.
9. Kirkham, M., 1989. Midwives and information-giving during labour. In: S Robinson, A Thompson, Eds. Midwives, Research & Childbirth vol. 1. London: Chapman & Hall, 117-138.
10. Hodnett, E.D., Gates, S., Hofmeyr, G. J., Sakala, C., Continuous support for women during childbirth (Cochrane Review). In: The Cochrane Library, Issue 2, 2008. Chichester, UK: John Wiley & Sons, Ltd.
11. Walsh D (2006) Risk and Normality in Maternity Care. In A Symon (ed.) Risk and Choice in Childbirth. London: Elsevier Science
12. Lauritzen S, Sachs L (2001) Normality, risk and the future: implicit communication of threat in health surveillance. Sociology of Health & Illness 23(4):497-516
13. Kirkham M, Morgan R, Davies C (2006) Why Do Midwives Stay? Women's Informed Childbearing and Health Research Group. University of Sheffield
14. Curtis P, Ball L, Kirkham M (2006) Why do midwives leave? (Not) being the kind of midwife you want to be. British Journal of Midwifery, 14(1):27-41
15. Fuller ton J & Young S (2007) Outcomes of Planned Home Birth: An Integrative Review. Journal of Midwifery and Women's Health, 52:323-333
16. Jabaaij L, Meijer W (1996) home birth in the Netherlands: Midwifery related factors of influence. Midwifery, 12(3):129-135