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Mixing the Message

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Rachel Reed highlights some of the confusing information given to women

The concept of 'early' or 'latent' labour emerged as a result of the birth process being broken down into stages which rely on clinical assessments of contraction pattern and cervical dilatation. The notion of being able to determine the future progress of labour from such clinical assessments is not supported by research, yet it underpins maternity care.

Labour is the process by which a baby moves from the inside of a woman to the outside. It sounds simple, but it is an incredibly complex interplay of physiological, psychological and emotional factors which women often experience as a sense of separation from the external world, focussing within, and becoming immersed in the act of giving birth. During early labour the woman is beginning to move into this birthing state, regardless of measurable 'progress'. Some midwives use the changes in behaviour as women move through the 'birthing state' to estimate how close the birth is. However, just like clinical assessments, this is not entirely reliable as each labour is unique and anything you do to a woman in the name of assessing her progress or monitoring her baby has the potential to interfere with her labour by stimulating her thinking brain and altering her delicate and unique hormonal and emotional balance.

Hospital message: early labourers are not welcome

Women admitted to hospital in early labour are more likely to end up experiencing complications and interventions, including caesarean section.[1] There are two opposing explanations for this:

1. These women already have a dysfunctional labour which is why they are coming to hospital in early labour. This explanation is favoured by many hospitals, and their response is to augment women who do not progress according to protocol. The rationale is to avoid a prolonged, complicated labour, and there is a commonly held view that 'women don't want to be in labour for a long time'. I wonder if the women are consenting to these procedures based on adequate information, or just being asked if they want a shorter labour.

2. That exposure to the routine interventions of care in a hospital setting, including monitoring and other forms of listening-in, increase the chance of complications occurring because the longer the woman is in the system, the more opportunity there is to 'do stuff ' to her.

Women admitted to hospital in early labour cost the institution more because they are in for longer, increasing demands on services and staffing. Great efforts are made to deter women from settling

themselves in hospital during early labour. Antenatal classes warn women to stay away from hospital for as long as possible to avoid intervention. When women ring hospital to enquire about coming in they are advised to 'take a paracetamol, have a bath and ring back in an hour.' Women are also told to only come to hospital when their contractions are coming every five minutes or less, which is concerning because the pattern of contractions is not an indicator of when the baby will be born. Entire services have been devised (phone support/home visits) to support women to stay at home during early labour.[2] When women arrive at hospital they are subjected to invasive clinical assessments to diagnose 'established labour' before they are 'cleared' for admission to labour ward.

If a woman does manage to get admitted in early labour she is considered a burden by staff. She is likely to be put in a room and checked on occasionally and referred to as 'not doing anything', 'niggling', 'she should go home'. The midwife who admits her will be questioned and ridiculed at handover. The midwife allocated to her will most likely also be caring for a woman in 'real labour', and that woman will take priority. From a cost/staffing perspective early labouring women are an avoidable burden.

Seeking reassurance and safety

Findings from qualitative studies suggest that staying away from hospital during early labour can be challenging for women, and the experience of being assessed as 'not in labour' and sent home can be distressing and result in women feeling unsupported3 and vulnerable. The need to be in hospital is not necessarily about needing pain relief or support, some women want to be in the place where they will give birth during early labour despite feeling that they were coping well at home. Some women feel uncertainty about the safety of their baby and themselves whilst at home and are keen to transfer to hospital in order to hand over the responsibility for safety to midwives early enough.

Women also expressed uncertainty about identifying when established labour begins. Women worry about going to hospital too soon or too late, and can be unsure of how to know if their labour is 'the real thing' without assessment by hospital staff. Women perceive midwives as 'gatekeepers'[3] with whom they have to negotiate in order to gain access to the hospital, and a labour that is not following a prescribed pattern risks the message that 'this is not right' or 'don't trust your body, trust us'.

Physiology and contradiction

Like all other mammals, labouring women seek a private and safe place where they can avoid distraction and immerse themselves in the act of birthing. During early labour women seek a place to settle and 'nest'. This makes perfect sense because whilst the neocortex is still engaged and can slow contractions (by reducing oxytocin) in response to thinking, a woman can think clearly and do the practical things involved in a physical move. Once the woman is settled and her neocortex is not being stimulated, increased oxytocin release re-establishes contractions. This explains why labour often slows down in response to the move to hospital. However, as labour progresses the limbic system takes over and it becomes more difficult – and dangerous from an evolutionary perspective – to move from place to place. The neocortex is suppressed and the woman is deeply in an altered state of consciousness. Simply asking

if you can listen or check can be enough to engage a woman's thinking brain, especially if she wishes to decline, and can disrupt the pattern of her labour. A woman who arrives at hospital already 'separated' from the external world does not stop her contractions, and she is often unaware of those around her until after the birth. The need to settle into the birth place during early labour is a normal response to the physiology of the birth process. It is also common for women to call on the support of other women during labour – women they know and who they feel safe with – relatives, friends, midwives, doulas, and early labour is a woman's signal to get settled somewhere safe and to gather her 'women-folk' around her.

What is considered a 'safe place' is influenced by the culture in which the birth is taking place. Western women are urged to birth in hospital because the cultural concepts of 'safe' involve medicine and technology. The experts in birth being the people who know how to use the medicine and technology and who can carry out assessments to determine wellness and progress. This message begins in pregnancy as women undergo routine clinical assessments with an emphasis on professional experts providing reassurance of wellbeing and continues through practices such as monitoring baby and altering the monitoring frequency in line with 'progress'. Women are also bombarded with fear-based media about the dangers of birth so it is not surprising that women head for the 'safety' of the hospital in early labour. Our culture has replaced the home/birth hut and well known womenfolk with the hospital and unknown medical staff.

The emphasis on hospital as a place of safety whilst also encouraging women to stay away results in some very contradictory messages for example:

'We are the experts in your labour progress, only our clinical assessments can determine what is happening … but we'd rather you do not come in to be assessed, and instead stay at home not knowing what is going on.'

'Trust us – we want you to have a good birth experience … but if you come in too early we are likely to create complications which will require intervention … so keep away as long as you can.'

'We are the experts in your labour progress, our clinical assessments can predict your future labour progress and we will send you home if you are found to be in early labour … but if you then birth your baby in the car park it is not our fault as birth is unpredictable.'

'This is a safe place to labour …. but you can only access this safety when you reach a particular point in your labour, preferably close to the end of your labour, you should do most of it on your own, away from our definition of safety.'

These contradictions result in a very annoying double standard: A woman who labours at home and comes into hospital 'fully and pushing' is praised – 'she did a great job'. However, she laboured (perhaps for many hours) without professional attendance or any monitoring. On the other hand, a woman who plans a home birth with a midwife is considered to be doing something unsafe, despite the constant attendance and monitoring of her midwife, and one who remains at home to complete the birth without attendance is often treated with horror.

Suggestions

Rather than considering how to prevent women in early labour being admitted to hospital, it may be better to explore how women's needs during early labour can be accommodated by the maternity system. I believe:

- Antenatal care should centre on building self-trust and reinforcing the woman's expertise in birthing her baby. If she relies on herself to determine wellbeing and progress she may be less likely to head to hospital early for reassurance. First time mothers who manage to remain at home during early labour express a sense of power. Maintaining power is often the central focus and involves a sense of authority over their own body.[4]
- We should give early labour respect. It is an important part of the birth process and women deserve recognition for it. The terms 'latent' or 'not established' are not helpful. The woman has begun the birth process. She has her signal to seek a safe place – if she calls on you, help her do this.
- Women's access to their birth space should not rely on them meeting arbitrary measurements which involve invasive clinical assessments. They should be able to use early labour to get to their 'safe place' and settle for birth.
- If women are planning to head to hospital while deeply in the altered state of labour it might be useful to take along a doula who can advocate and use her neocortex while the woman's is suppressed.

Of course for a woman birthing at home it is a different kettle of fish. She doesn't need to concern herself with 'when to go to hospital' – and her support should attend based on if and when the woman needs her, not when she meets particular criteria. However, not all women want to birth at home, or have the support to, therefore, the systems in which they birth need to change.

The essential problem is that maternity care has developed in response to the needs of institutions, not the needs of women. Unfortunately the woman-centred, continuity of care that woman want is the exact opposite of the hospital-based, fragmented care that is already deeply embedded in our society.

References

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