AIMS For a better birth...

Reinstating Women's Time in Childbirth

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An article on pregnancy and new motherhood which appeared recently in Ireland's largest daily newspaper, the Irish Independent, assured women that we can approach labour 'with a positive attitude'. This is because labour 'will not last longer than 12 hours in most Irish hospitals. The medical staff will intervene if the "established" labour has been going on for longer than 12 hours' (Irish Independent, 11 March, 2000:12).

With no explanation about what these interventions might consist of, and indeed with no alternative account of how to view labour and no discussion of where this mysterious 12-hour timeframe had come from, the article was upsetting to read for anyone who knows the arguments that lie behind such assertions. How are newly pregnant women to get a different message about birth if the mainstream medical argument that favours active management of labour gets such unquestioning press coverage?

Childbirth in Ireland

And yet, there is a growing sense for anyone involved in and concerned about childbirth and midwifery in Ireland, that at last, some fundamental changes are afoot and that the confidence that has been invested in active management strategies is beginning to waver. In September, 1998, after hearing hundreds of submissions from midwives who were deeply troubled by the depth and the extent of medicalised childbirth which had reduced them to mere 'obstetric nurses', a government-appointed review committee issued its recommendations for the future of Irish nursing and midwifery. Amongst a raft of changes, the Commission on Nursing, headed by a senior member of the judiciary, stated that as a matter of urgency, the Department of Health must:

- acknowledge in legislation the separate and independent nature of midwifery as an autonomous profession;
- reform the theoretical teaching of midwifery;
- establish direct entry midwifery training;
- and establish domiciliary birth as a real option.

A national strike of nurses and midwives in 1999 ended with a legal ruling to have these and other steps implemented at once and the first direct entry midwifery course, based in Trinity College Dublin, will begin in June of this year.

Alongside the careful work by midwife teachers and tutors to bring about changes in the syllabus, the establishment of direct entry training points to a new climate of renewed energy for midwives. We are even hopeful that the long-running and anguishing legal battle which was visited on one of our independent midwives, Ann Kelly, as a way by mainstream medical staff, deeply opposed to independent midwifery and home birth, to damage its status irrevocably, may finally be reaching a conclusion in Ann's favour. With the challenging and disturbing data from researchers like Cecily Begley on the lowered state of morale amongst midwifery students and the sheer problem of midwife shortages (Begley, 1997), one must say not before time that we have had some good news.

We know that we still have a distance to go to restore a midwifery model of birth which respects and encourages women to give birth in their time and according to their rhythms. For example, the pilot domiciliary birth and domino programmes which have been set up by the National Maternity Hospital in Dublin and in Galway, by University College Galway Hospital, are operating on criteria as far distant from evidence-based care as they can be. These schemes limit participation to those women who are designated 'low-risk' and who live within a 3-mile radius of the hospital and exclude women who live in multi-story buildings within that radius. This is for fear that transporting a woman in labour on stretcher cannot be accomplished quickly enough in such circumstances. Indeed these programmes in their entirety can be said to be fear-based.

They certainly do not reflect a thorough examination of the evidence around what secures safety in birth, and do not appear to have even a nodding acquaintance with the data-based reviews that present conclusive findings on the lack of any cause and effect relationship in the presumed statistical association between the increase in hospital-based deliveries and the fall in perinatal mortality (Campbell and Macfarlane, 1995; Tew, 1995).

The strength of this fear-based medical model and the absence of attention to evidence-based care can be seen in the ever-rising rates of interventions in Irish maternity hospitals. A minimum 27 per cent of all births in Ireland end as instrumental deliveries, either forceps, Caesarean section or ventouse, and current rates of intervention in the three major Irish teaching hospitals range from 45 per cent to 67 per cent for the epidural; 43 per cent to 60 per cent for episiotomies on first-time mothers, and with Caesarean section rates ranging from 13 per cent to nearly 25 per cent. Thus it can be seen at a glance

that the medical model which distrusts women's bodies in labour and submits them instead to the absurdities of the partogram and the injunction of active management that all labours be completed in under twelve hours, remains very strong.

Under these circumstances, it is a real challenge to committed midwives and childbirth activists to get the meanings and the sense that lie behind evidence-based care communicated to women, to give them the tools with which to begin to reject the fear-based medical model with its fantasies of pathology around every corner.

Midwifery model is better and safer

We know that the midwifery model of birth is better and safer. The Cochrane database now lists eleven controlled trials on the social or midwifery model of birth that demonstrate statistically proven better outcomes for women with this approach to care. Reported results from these studies conducted over the last decade in hospital settings in at least seven Western countries include:

- shorter, less painful labours;
- less likelihood of intrapartum analgesia;
- less likelihood of operative vaginal delivery;
- and for babies, better Apgar scores at five minutes

when compared with the medical model of labour and birth (WHO, 1997). Social support, in the randomised controlled trials listed by Cochrane, is defined as comprising advice and information; tangible assistance and emotional support through continued presence; listening, reassurance and affirmation. Social support during labour and birth, preceded by continuity of care, with the same care giver or team of caregivers during pregnancy who also attend the birth can greatly improve a woman's levels of stress and her feeling that she is fully competent to handle birth. Her physiological outcomes will also be improved.

The Cochrane-listed controlled trial of women receiving continuity of care indicated that women in this group were less likely to:

- Have labour augmented;
- Have a labour of > 6 hours' duration;
- Have a baby with a five minute Apgar score <8. · (Enkin et al., 1995: 15-16).

In a social model of birth, it is the woman who is at the centre of the birth process, the midwife who helps her through the process. With this approach to birth, her own personal time is restored to each woman, time to labour at the pace of her own body, in relation to her needs and those of her baby, rather than the abstractly defined workings of the 'average body' found in obstetrics textbooks.

Inconsistencies in the medical model

What is such a puzzle is why the medical model of birth contains such vast inconsistencies, like the argument that there is an 'average' labour, and also why mainstream obstetric thinking has such a selective and faulty memory. The result of inconsistent and selective thinking and practice is that even when results of good controlled trial studies are available, like those mentioned above, their findings are not mainstreamed.

Why, for example, when there is excellent evidence on the value of the vertical or upright axis or angle during labour and birth, are so many women still asked to get into a supine or semi-supine position when giving birth? We know that giving birth using a vertical axis reinforces good maternal outcomes because the length of labour is reduced, pain is lessened, and because it helps prevent complications like postpartum haemorrhage, because gravity aids the birth of the placenta (Caldeyro-Barcia, 1960; Schwarcz, 1976, Caldeyro-Barcia 1980).

On the other hand, the Cochrane database states that the supine position during labour results in a significant reduction in cardiac output, a reduction in the intensity of contractions and reduced efficiency of contractions. In other words, there is a good probability that the supine position will help extend the length of labour, and could thus potentially expose a woman to the medical schedule of interventions which come into play to meet the 12-hour rule.

Why, then, with proven benefits to the vertical axis in labour and birth, and proven drawbacks to positions with a horizontal axis does obstetric practice still favour the latter? Why should the onus be on the woman to argue her case for the most advantageous position in birth? Why must mainstream obstetric practice continue to be so blind about its own research? Why do they not want to work with the body in labour? Why must so many of the medical technologies seek to overcome, override and overpower the body in labour?

Of course in relation to the supine or semi-supine position, mainstream obstetric thinking argues that birth attendants must be able to see if anything is going wrong. There is no belief that birth is far more likely to go right than wrong with intelligent supportive practices.

By contrast, mainstream obstetric thinking does believe that unless its rules are followed, women run the risk of the death of their babies. This is despite the fact that the teaching on risk is deeply flawed. Obstetrics cannot really effectively divide women into high-risk and low-risk categories, because any given set of risk factors or schedules will pick up some women but fail completely to identify others. Frequently what happens is that many women who have been put into a high-risk category, never develop the complications for which they were thought to be at risk, while some other women do go on to develop unexpected complications (Maine, 1991).

What needs to be done?

We have to make women aware that the identikit version of women's labours promulgated by active management strategies, which is slapped on them before they begin, cannot be called an adequate care

system.

We need to make it crystal clear that the best way to organise midwifery care is with ongoing supportive practices which can best help women in labour. This kind of continuity of care will see most women successfully through childbirth, while being able to identify problems, if they do arise. We need to be able to convince women of this, especially younger women who have a different relationship to technology and who also, doubting their capacity to get through labour without technology, opt for the epidural or the elective Caesarean, not realising that birth need not be done that way, that they do not have to become cyborgs, half-woman, half-technology in order to give birth well.

Although it often feels to those of us working in Ireland that here we endure the worst of the medical model of birth, I am personally under no illusion. This challenge of enabling women to see birth differently and as their own positive accomplishment is a challenge in every country in the Rich World at this point. I think it is important to emphasise that this is not simply about giving women choice or a gentler atmosphere during birth, the so-called Laura Ashley flowered curtain approach.

It is about giving women the maximum physical, psychological and emotional support to enable them to give birth in ways that produce the best outcomes for them and their babies. We urgently need to get over the message that midwives are the caretakers of normal birth, that they have the skills and the capacities to help women throug uncomplicated labours to their best advantage; that given time, quiet, peace of mind and sensitive support, women can give birth in the best way possible for themselves and their babies without resorting to the cyborg route.

References

Begley, C. (1997) Midwives in the Making: a Longitudinal Study of the Experiences of Student Midwives during their Two-Year Training in Ireland. Unpublished Ph.D. Thesis, University of Dublin, Trinity College.

Caldeyro-Barcia, R. (1960) Effect of position changes on the intensity and the frequency of uterine contractions during labour. In American Journal of Obstetrics and Gynecology, 80.

(1980) Approaches to Reducing Maternal and Perinatal Mortality in Latin America. In R.H. Philpott (ed.)Maternity Services in the Developing World - what the Community Needs. Proceedings of the Seventh Study Group of the Royal College of Obstetricians and Gynaecologists, 1979. London:RCOG.

Campbell, R. and Macfarlane, A. (1995) Where to be Born? The debate and the evidence. Second edition. Oxford: Crown Publications for National Perinatal Epidemiology Unit.

Enkin, M. et al. (1995) A Guide to Effective Care in Pregnancy and Childbirth. 2nd Edition. Oxford: Oxford University Press.

Irish Independent (11 March, 2000) Easing the Pain. In Mothers and Babies, Supplement, Irish Independent.

Maine, D. (1991) Safe Motherhood Programs: Options and Issues. Prevention of Maternal Mortality Program, Center for Population and Family Health, Columbia University: New York.

Schwarcz, R. et al. (1976) Influence of amniotomy and maternal position on labour. In Proceedings of the VIII World Congress of Gynaecology and Obstetrics. Amsterdam: Excerpta Medica.

Tew, M. (1995) Safer Childbirth? A Critical History of Maternity Care. Second Edition. London: Chapman and Hall.

WHO (1997) Reproductive Health Library. WHO/HRP/RHT/RHL/1/97. Geneva: Author.