But Whose Art Frames the Questions?

Midwives need to be vigilant to ensure the defining of appropriate midwifery practice has not been colonized by obstetric thought. Any guiding must reflect the essential Midwifery Model of Care in the evidence amassed and the way in which it is applied.

The *Guidelines for midwifery led care in labour* [1], clearly a document involving a great deal of work, leaves me feeling uneasy about the result. The underlying theme of these Guidelines seems to have been to pick apart obstetric practice in the hope of exposing what midwifery care is about, rather than looking to how a woman births; what her needs are and how a midwife can impact positively within the relationship. The issues of birth environment, nutrition in labour, positions in labour and birth, rupture of membranes, placental delivery and care of the newborn in these Guidelines are worked to counter the negative effects of obstetrical interference. If midwives believe birth is potentially a physiological event, why is so much emphasis placed on gathering evidence to show obstetric care is detrimental to normal birthing? Why are the physiology, biology and sociology of childbirth not the focus of these Guidelines?

To give an example ~ the physiological means to assess the unborn baby in labour are ignored. Instead the RCOG guideline for monitoring every fifteen minutes in 'first stage' and following every contraction in 'second stage' has been adopted ~ a regime that will undoubtedly ensure the physiology of birth is disturbed. Isn't it more appropriate to evaluate the unborn baby's wellness state in ways that do not interrupt her labouring?

The noting of a baby's movements in pregnancy is a well-accepted assessment of the unborn baby's wellness and integral to both midwifery and obstetric practice. The majority of babies continue to have periodic movements in labour when their mothers are neither sedated nor anæsthetised. This phenomenon will be familiar to midwives who have witnessed physiological birth ~ that is, spontaneous, non-medicated childbirth in familiar, non-threatening surroundings.

These midwifery observations are supported by the literature that confirms the different behavioral states existing in pregnancy (distinct periods of sleep and activity in the healthy unborn baby) continue to be present in labour.[2; 3; 4.] As in pregnancy, movements in labour are accompanied by accelerations of the baby's heart rate. Again, these are a sign of the baby's wellness and are a normal, healthy response to the normal and healthy stresses (not distress) of labour.[5] The difference between the Medical and Midwifery Models of Care is that the former values only machinery to assess and verify movements, whereas the latter validates verbal feedback by the woman and visual or tactile observation by the midwife.[6; 7.]

If Guidelines are to be used in an attempt to frame evidence-based and appropriate midwifery practice they should reflect activities that at best enhance the process or at worst do not interfere with it. Therefore the question would not be 'how often does one listen to the unborn baby in labour' but rather 'how can the midwife gather this information and cause minimal or no disruption to the labouring woman?'

While the authors have stated their intention not to be prescriptive, the practice reality so often actions such Guidelines in a prescriptive manner and they quickly become claimed as standard practice. This 'standard practice' is passed on to student midwives as midwifery knowledge, which the following practice incident illustrates.

I was asked by a student midwife, "What is your time frame for placental delivery?" Her task was an assignment on the 'third stage' of labour. We had attended a woman together five weeks previously who had given birth to her placenta in the shower one and three quarter hours after the baby's arrival.

During the pregnancy (her sixth) the woman had expressed a strong fear about her ability to cope with the last moments of labour when she had no control and had always found nothing eased this time. This sixth labour had been no exception. The moments before her need to push, she was caught in her own personal hurricane. A harsh acceleration phase just prior to pushing overwhelmed her ability to continue standing, and she had gone low on all fours on the bathroom floor. The waters broke and the baby's head was born over one smooth surge. She was unresponsive to my request to rise up slightly so the baby had room to be born. My gentle lifting of her buttocks resulted in her exclamation, "I have been asleep!" She raised herself slightly and the baby was born into her husband's hands, passed between her legs and into her arms.

For half an hour or so after the birth she re-established her links with her husband and calmed her baby daughter, who had her own story to tell. As the woman re-entered the world, she continually remarked how she had lost the conscious awareness of her surroundings. It took her a longer time than usual to put her baby to the breast and to recover her headspace. Giving her a cup of tea and toast as she settled down refocused her on the recovery from birthing.

With after-pains, she squatted over a bucket and pushed but produced nothing. With the next group of pains, she also drew down gently on the cord, which turned into a stronger pull but to no avail. She looked drawn and tired, and as if she was starting to suffer from performance anxiety. The best place for her was in bed until the placenta was ready to come. As she was in need of a shower, this preceded the familiar groan of delight we would hear of a woman climbing into bed after childbirth. Thus, the placenta came in the shower as she melted into the spray of hot water.

This woman had previously suffered the consequences of medicalised maternity care in her first two labours ~ the first, an induction of labour for an uncomplicated post dates pregnancy, a 'normal' birth and a sutured first degree perineal tear. In her second labour, an internal examination resulted in her waters breaking 'spontaneously' and she went on to have a 'normal' birth. She was given the routine intra-muscular Syntometrine in preparation for controlled cord traction, during the performing of which, the cord avulsed. This was followed by a manual removal of her placenta under spinal anæsthesia. She had since sought care to ensure her ability to birth well would not be sabotaged and had birthed at home for her third and subsequent babies.

At the time, I had not thought anything of a time frame for placental delivery and I was brought up short by the student's question. My mind was intent on the woman's need for rest, recovery and re-centering of her birthing energy. After this baby's birth, the latter was dissipated by

discussion about her 'asleep-ness' while the baby's head was born and a congratulatory call from relatives. For this woman, there were the essentials for the physiological process to be restored before any pathological solutions would be considered. Time was only one factor and in this situation was least significant.

The student spoke of familiar obstetric time frames ranging from twenty to sixty minutes, after which time, a placenta was considered retained. However, these time frames were given as examples of midwifery practice.

Many such practice incidents as described above leave me believing that 'Guidelines' are a counter productive tool for midwifery practice. In the depth and breadth of women's experiences of childbirth defining normality is not just problematic ~ it is impossible. Just as the meaning of midwife (with woman) is defined in the singular, practise of the midwife's art and science must be tailored to the individual woman. Any attempt to alter the unique focus of midwifery practice needs to be examined to expose who benefits when midwifery is contained and distinct boundaries are set as to when women 'require' medical intervention.

It is common to hear 'Guidelines are for the consideration of the wise and the adherence of fools'. This innocuous representation does not hold true to midwifery experience. A great deal of power is given to Guidelines in case and practice reviews, auditing and disciplinary proceedings. This impacts on how far a midwife can 'stray' from the dominant medicalised culture of birth.

With the status 'Guidelines' have, we cannot afford to show tacit approval by our silence. Instead we can honour the intent the authors have shown in attempting to turn around the undermining of midwives' and women's confidence. Their Guidelines can be a catalyst to help identify our own midwifery discipline and how best to apply the 'how it really is' that women in childbirth can teach us. It is this more appropriate enquiry into midwifery fundamentals that will guide and hasten the reclamation of our distinct midwifery knowledge.

Citation reference:
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