Humanisation of childbirth 8: Where do we go from here?

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Summary

In this eighth and final article of the 19th midwifery basics series on Humanising Birth, the authors revisit the important tenets of the humanisation of childbirth and provide ideas for progressing this concept into the future of maternity care systems. Ideas discussed in this paper have been published in an article by Professor Lesley Page in Deutsche Hebammen Zeitschrift, titled (in English) Humanising birth: crucial for resilience sustainability and humanity for the future, and in German Die Humane Geburt: Zeit für den Wandel!¹ and by Dr Elizabeth Newnham and colleagues in Towards the humanisation of birth: a study of epidural analgesia and hospital birth culture.²

The critical need to humanise birth

In her recent article written for a German practicing midwife journal, Lesley Page made the comparison between childbirth dehumanisation and overmedicalisation, and the crisis of climate change. They are both issues of global importance, and yet there is scant awareness of the critical implications of the problems of dehumanised and overmedicalised care. Perhaps they are a part of the same crisis: reliance on outdated industrial models; on the belief that we can interfere with delicate and complex
processes of physiology or ecology without disturbance; that we are all self-reliant individuals (a byproduct of capitalism and neoliberal politics); that we do not require fundamental social processes of support and community and allow commercial interests to dominate care. These late modern beliefs and practices are at the heart of the overmedicalisation of birth. However, the consequences of disturbing birth physiology are also becoming clearer, and may not only disrupt the immediate mother-baby dyad, but also impact on the health of future generations through epigenetic change.

**Revisiting humanisation of childbirth**

Humanising birth is a response to this problem. It is an approach, a way of thinking about birth, that moves away from medicalisation and institutionalisation – moves away by building systems of care that respect the complex processes of physiology and social support, that respect the need for true autonomy and justice, and that provide individualised compassionate and respectful care to all women and their families. The idea of humanising birth can be used by individual practitioners in their daily work to develop awareness to encourage critical and big picture thinking, to establish systems of care, and redesign healthcare services.

According to the findings discussed in Towards the humanisation of birth, midwives should be aware that women do not necessarily come into labour with a specific plan: women expect support, comfort, suggestions for coping and identification of the abnormal. They expect that their bodies be respected. They expect that birth physiology will be supported.

Women’s experiences of birth are strongly influenced by the attitude of the midwife and rely on the development of a trusting relationship (the ‘circle of trust’ – see the second article of this series). This seemingly simple factor is complicated within institutional/industrial birthplace because it puts midwives in a position where they are attempting to facilitate a trusting relationship on one hand and work within medicalised and prescriptive hospital policy on the other. It also undermines women’s expectations – as they are expecting to be offered choices that actually do encourage normal birth. This disruption of the midwife-woman relationship by the institution can be detrimental to both women and midwives.
Trust and the industrial model

The issue of trust – so central to childbirth – is complex. One of the fundamental principles of the medical model of childbirth is a lack of trust in the woman’s birthing body (and a corresponding faith in science and technology to ‘fix’ the faults). Add to this a longstanding gendered history of control over women and reproductive processes, and the end result is a flawed system that, generally, fails to see its own shortcomings. This situation leads to a lack of trust, by some women and some midwives, in the medical system. While this can lead to a reclaiming of birth space and knowledge production, and the provision of alternative models, other consequences include a complete lack of engagement with any health provider, or non-disclosure of complications, thereby increasing risk. The flipside is complete faith in a medical system that cannot always deliver on its promise of healthy mother, healthy baby, which introduces risk and iatrogenesis through overuse of intervention, and which cannot incorporate individualised care into its industrialised model. What is needed is for trust to build between the obstetric and midwifery professions. However, birth remains contested territory under dominant discourses of risk and safety. Policies that restrict ‘normal’ birth practices and facilitate ‘medical’ ones further embed these discourses. The paradox of the institution (see the fourth article in this series) – the entrenched surveillance and momentum that seeks to keep women safe by pushing them through – potentially puts women at risk and puts midwives in a contradictory position as both guardians of normal birth and risky practitioners.

Prioritising place of birth

We suggest the critical revision of the assumption that a hospital labour ward should be the primary place of birth. Implementation of alternative birth settings should be prioritised and midwives the lead providers of maternity care for most women. Homebirth services need to be supported by infrastructure and positive interdisciplinary culture. In instances where women need to birth in hospital labour wards, practices that support physiological birth, such as continuous labour support and the use of water, should be viewed as best practice. Where normal birth is not possible, supportive trusting relationships should still be facilitated.

This is not a narrow focus on ‘normal birth’ outcomes – it is about maximising the potential of physiology and paying attention to the process. Dahlen notes that ‘keeping birth normal is at the heart of building trust – building trust keeps birth normal’. This will be the beginning of a humanised birth culture that attributes trust, power and
respect to women’s bodies. One that places women at the centre of the birth process and prohibits unethical actions. Disrespectful and abusive behaviours in maternity settings frequently fly under the radar due to narrow definitions of ‘informed consent’ and ‘bodily autonomy’ that do not acknowledge discourses and relationships of power. In fact, humanisation is very much about confronting our illusions, or perhaps delusions, about what is safe. We cannot, given the evidence, continue to support the belief that hospital birth is safer than out of hospital birth, or that high caesarean section rates are safe. Hospital birth and caesarean birth might be safer for some women and some babies, but not all. So, the development of personalised care, or woman-centred care, is at the very heart of humanisation. The provision of individual care, which meets the personal and physical needs of each woman, her baby and family and responds to her preferences and life situation, requires a shift in systems of care in our institutions, to emphasise the importance of relationship formation over time (continuity of carer (CoC)). An essential part of the relationship is in the art of respectful conversations, always listening to the woman and responding to her needs and values. It is about being able to convey good information, understand and convey the evidence and help the woman apply it to her own situation and, ultimately, to make her own decision about her care. Therefore relationship-based CoC is key to humanised approaches.

**Concluding thoughts**

But perhaps above all, humanised birth is concerned with recognising the deep significance of the birth of a baby, the woman becoming mother, the partner becoming parent and a new family being formed. Pregnancy, birth and the weeks after are a critical sensitive period in which midwives may contribute to this strong relationship, which is the foundation to health, wellbeing and emotional resilience through life.

A secure attachment is a building block, a cornerstone, to a life of more positive relationships, improved wellbeing and greater empathy and altruism. This support for a secure attachment comes not only from sensitive and responsive support of the woman and her partner, but also support of physiological processes and avoiding disruption to the physiological basis of love as much as possible. The birth of every baby is the birth of our humanity. The humanisation of childbirth is therefore, fundamentally, about the perpetuation of love and a more optimistic future for humankind. **TPM**

**Future steps and points of reflection**

The circle of trust can provide a useful model to understand the relationships and influences described by women and required of midwives and a template for humanised birth practice.

Consider reading about the circle of trust model and incorporating an understanding of the model into your practice.
A renewed focus on ‘midwifery technology’ – with an emphasis on the continuing importance of research, education, documentation, dissemination and support of knowledge and practice that facilitate normal birth.

Share your midwifery ‘knowledge of art and skill’ with each other. Talk to colleagues, organise interdisciplinary journal clubs or study days.

That midwives acknowledge their disruptive potential as the nexus between women and medical discourse. That they hold firm to the central mother-midwife relationship and notice if/when the institution gets in between this.

Consider your interactions with women. Do they contribute to or question dominant medical discourse? Pay attention to the times if/when hospital policy causes conflict or disrupts the mother-midwife relationship. What affect does this have on trust, on ethical practice, on your feelings about your practice?

References

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