Role of the midwife in care interventions

Title: Discuss the following statement in relation to birth. Midwifery expertise is as much about knowing when not to interfere in the physiological process of pregnancy and birth as it is about recognising when and how to intervene in a way that will facilitate and enhance the woman’s ability to give birth.

Essay

Women have been giving birth throughout the ages. On the one hand this can be regarded as a normal physiological process which has evolved over the millennia to be a successful method of perpetuating the species and like most evolutionary honed processes, is likely to work well most of the time. On the other hand, as any experienced clinician knows well, any physiological process has the ability to malfunction. A large proportion of professional medical care in any field of medicine is to be able to recognise the normal variations and differentiate them from the abnormal. As a general rule it is only the abnormal that requires treatment or intervention. (Hunt T 1994)

Hippocrates is reputed to have said that it is the first rule for a physician that “ one should do no harm”. (Carrick P 2000). In a modern context, this often means “ leave the normal alone” as the ability to produce iatrogenic complications is well known. (Halpern S D 2005)

If we restrict ourselves to the consideration of the field of midwifery, the preceding statement can be well illustrated in the writings of Dr Ignaz Semmelweis who was horrified by the levels of puerperal fever that was killing nearly 40% of the pregnant women on his wards. (Semmelweis I P. 1861). Although he discovered the concept of asepsis from his observations,

we note that on a simple level, the vast majority of the morbidity and mortality in this case was caused directly by the intervention of the healthcare professionals in what were otherwise normal pregnancies.

On a matter of more immediate concern we can consider the issues relating to stress incontinence as being an excellent illustrative example of how midwives can elect to intervene during pregnancy and the birth process in order to facilitate not only the birth process but the whole area of potential morbidity surrounding maternity in general.

Pregnancy itself is an independent variable risk factor for stress incontinence (Rortveit et al 2003). Although the midwife is not generally involved in the very early stages of pregnancy, there is good evidence that prenatal involvement in terms of preparation of the woman for the process of childbirth will reduce the incidence of stress incontinence post partum. (Reilly E T C et al. 2002). Instruction in the practice of antenatal pelvic floor exercises has been shown to reduce both the incidence and severity of pelvic floor damage during parturition (Salvesen et al. 2004)

At the time of the delivery the midwife can make a number of interventions which will help to reduce the eventual morbidity including having the knowledge that a large birth weight baby is more likely to produce pelvic floor damage and will therefore be more likely to consider doing a prophylactic episiotomy to minimise the potential for pelvic floor damage. Equally, in the time prior to the actual delivery, her intervention to establish the lie and orientation of the baby will help to prevent malpresentations and the associated possibility of instrumentally assisted deliveries with the

attendant possibility of resulting morbidity.(Norton C. 1996) Part of the acquisition of professional skill during training is to gain the knowledge which allows the ability not to intervene if the pregnancy and delivery are proceeding smoothly.

Unnecessary intervention also has a more subtle downside in that it encourages dependence by the mother on the midwife. On an ethical dimension one can argue that this unnecessary dependence erodes the patient’s autonomy. (Coulter A. 2002). During pregnancy and birth, many women will find it all to easy to be subsumed by the medicalisation of the birth process. The professional midwife should be aware of this phenomenon and try to reduce its effect as far as possible. For many women, the midwife becomes the foremost trusted healthcare professional for the majority of her pregnancy and is the first point of contact with the medical establishment. The woman implicitly comes to trust the midwife’s professional status and believes that the midwife will do what is necessary but not what is unnecessary. The midwife’s professional status is therefore based ultimately on this premise, and a sound professional judgement based on a firm evidence base, is central to her ability to produce benefit when she decides that intervention is necessary. (Paine L L et al. 1999).

An area where non-intervention is actively practiced is during the third stage of labour where the experienced midwife will observe and allow the fundus to contract rather than immediately intervene to deliver the placenta. There is a delicate line to be drawn between actively delivering the placenta too soon and thereby increasing the risk of uterine haemorrhage or uterine inversion, and not intervening at all and allowing the placenta to become

entrapped in the contracting uterus with the implications of having to do a manual removal of the placenta possibly under a general anaesthetic. (Romero R et al. 1999).

In conclusion we can consider that the role of the midwife is primarily to assist the pregnant woman through her pregnancy, her delivery and in the immediate post partum period. As we observed at the beginning of this essay, it is quite possible to intervene at virtually every stage of this process, but we would suggest that it is inherent within the role of the professional midwife that she should be able to draw a distinction between those occasions where intervention is mandatory, those when intervention is prudent and those occasions where it is perfectly appropriate to do nothing.

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