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Women's expectations and experiences with labour pain in medical and midwifery models of birth in the United States

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ABSTRACT

Background: This research focuses on how women understand and experience labour as related to two competing views of childbirth pain. The biomedical view is that labour pain is abnormal and anaesthesia/analgesia use is encouraged to relieve the pain. The midwifery view is that pain is a normal part of labour that should be worked with instead of against.
Aims: To determine differences in the preparation for and experiences with labour pain by women choosing midwives versus obstetricians.
Methods: Prenatal and postpartum in-depth semi-structured interviews were conducted with a convenience sample of 80 women in Florida (United States): 40 who had chosen an obstetrician and 40 who had chosen a licensed midwife as their birth practitioner.
Findings: Women in both groups were concerned with the pain of childbirth before and after their labour experiences. Women choosing midwives discussed preparing for pain through various non-pharmaceutical coping methods, while women choosing physicians discussed pharmaceutical and non-pharmaceutical pain relief.
Conclusions: Equal numbers of women expressed concerns with childbirth pain during the prenatal interviews, while more women choosing doctors spoke about pain after their births. Women had negative experiences when their planned pain relief method, either natural or medical, did not occur. The quandary facing women when it comes to labour pain relief is not choosing what they desire, but rather preparing themselves for the possibility that they may have to accept alternatives to their original preferences.

1. Introduction

Pain is a biological, psychological, and cultural experience that involves both physical stimuli and emotional and cognitive processing, which often occur within specific social and cultural contexts. The International Association for the Study of Pain (IASP) defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."[1] Giambardino describes labour pain as a "perfect model of acute pain" being both somatic and visceral in nature.[2]

Labour pain is situation specific, of limited duration, and contrary to many other sources of pain, is not indicative of underlying pathology, but part of a normal physiological process.[3] Labour is not pathological, in the sense that it is not a product of bodily harm but rather an indicator that the baby is ready to be born. Some authors have compared labour pain to the pain of running a marathon, as it is goal-oriented and finite.[3,4] Most people would not dream of interfering with a marathon runner's experience of pain in their quest to finish their race, yet women's experiences of pain during labour are often not given the same credence. This may be because pregnant women, the physicians, midwives, nurses, and other healthcare professionals who assist them in the birthing process, their families, and members of their social support networks, may have differing approaches and interpretations of labour pain. In the United States (US), the approach to labour pain management is one of the distinctions between obstetricians and midwives and concern about labour pain is central to the experiences of many pregnant and birthing women.[2,5]

Interpretive anthropologists focus on the meaning of health as interpreted by the individual, rather than on the specific health

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condition and are often critical of researchers for neglecting the lived experience.[6,7] Cultural factors that influence the way women experience labour pain come, in large part, from societal gender roles and expectations of behaviour and performance of pain. This means that women may express pain differently depending on whether they come from a culture that values outward expressions of pain or if they come from a culture that values stoicism. The aim of this interpretive anthropological research was to explore US women's personal understanding and experiences of labour pain, within the context of these contrasting models and approaches.

1.1. Contrasting models of labour pain

In the US, the dominant medical approach to labour pain reflects the premise that physicians have the responsibility to provide pharmacologic management of pain related to childbirth. This approach is evident in the statement released by the American College of Obstetrics and Gynaecology (ACOG) Committee on Obstetric Practice in 2004:

> Labor causes severe pain for many women. There is no other circumstance where it is considered acceptable for an individual to experience untreated severe pain amenable to safe intervention while under a physician's care. In absence of a medical contraindication, maternal request is a sufficient medical indication for pain relief during labor. Pain management should be provided whenever medically indicated.[8]

In 2011, the International Association for the Study of Pain released a clinical update detailing modern labour analgesia, which contained the assertion that the "epidural as the undisputed standard of care for all parturients seeking pain relief."[9] Using a neurophysiological model, obstetricians identify and treat the physical sensations of labour pain through the use of medication.[3]

In contrast to the medical model of pharmacologic intervention for *abnormal* labour pain is the midwifery approach, rooted in the assumption that childbirth pain is normal, necessary, and possibly empowering for the birthing woman. As described by Leap and Vague, the midwifery model is one of working *with* the pain rather than eliminating it.[10] Furthermore, this approach addresses not only the physical manifestations of pain but also the psychological, social, and cultural aspects. During labour women may experience both pain and suffering. If a labouring woman feels that she lacks the adequate resources to deal with the pain of labour, she will suffer. These resources can include pain medication, social support, and preparation for childbirth.[3] Conversely, if a woman feels prepared to cope with the pain of labour, she may not experience suffering.

1.2. Literature review

Pregnant and birthing women may find themselves caught in the middle of these two opposing approaches to labour pain as either natural or abnormal. Research with midwives, doctors, and women in Australia showed that midwives preferred physical relief methods, doctors preferred pharmacological, and women fell on a continuum between the two, however 98% of the women wanted a supportive person with them during the birth.[11] In the US, most women give birth in the hospital (98.9%) and the majority are attended by obstetricians.[12] The most recent statistics show that midwives attend about 8% of the births (both in and out of hospital) in the US.[13] Around 7% of hospital births are attended by Certified Nurse Midwives or Certified Midwives (both accredited through the American College of Nurse Midwives).[13] Certified Professional Midwives attend most of the out-of-hospital births (43%) and are certified through the national organisation the North American Registry of Midwives.[13] State licensed midwives as well as non-licensed midwives may also attend births in the United States.

A review of births occurring in 27 states indicated 61% of birthing mothers in hospital received epidural/spinal anaesthesia.[14] Compared to women in other industrialised nations, American women have a limited range of options to control pain during labour.[15] Although the research on American women's actual preferences for labour medication are limited, these data strongly suggest most women readily welcome the availability of epidurals and other types of medication.[14–16] In the United States, often women are expected to be nice and polite and put others' needs before their own.[12] When a woman's pain is inconveniencing others (such as hospital staff, other women birthing in the same room, or even their partner) she may acquiesce to receiving pain medication to make life easier for those around her, seriously affecting her lived experience.[17]

Using critical medical anthropology, Dudgeon and Inhorn demonstrated ways in which the dominant patriarchal model shapes policy and implementation of care that directly affects the choices women are able to make in their own reproductive care.[18] Lower class women have sought medical interventions and testing during pregnancy and childbirth because, throughout the past, equal access to treatment was denied to them.[19] At the same time, middle class women seek out education and may reject the technologies available to them. Depending on whether the mother-to-be characterises birth as a normal, natural process or a risky process that needs medical intervention, she may select a midwife or a doctor to be her practitioner.[20,21] The choice of birth practitioner directly affects how labour will be handled. For instance, licensed midwives in Florida are only allowed to use local anaesthetic from a prescription issued by a medical doctor, and therefore would not be allowed to administer epidural anaesthesia.[22]

2. Participants and methods

This research is based on data collected as part of a larger study of birthing experiences conducted in the State of Florida. The University of Alabama Institutional Review Board approved this study. Inclusion criteria were pregnant women age 18 or older, in the second or third trimester. I personally approached women in the waiting areas in the practitioners' offices, described the study to them, and invited them to participate.

I recruited a convenience sample of 80 women during their prenatal period; 40 women who had selected an obstetrician for their prenatal care and 40 who had chosen one of three licensed midwives in the area as their birth practitioner. Participants were not matched on demographic variables and came from a variety of different ethnicities, class levels, education levels, childbirth experiences, and family situations. Demographic information on the sample can be found in Table 1.

I conducted two individual, in-depth, semistructured interviews with each participant – one interview during the prenatal period and one postpartum interview. The aim of the prenatal interview was to explore the participants' cultural models and beliefs of pregnancy and birth and their feelings about pregnancy and birth, and to identify similarities and differences across the two provider groups, Prior to taking part in an interview each participant signed a written informed consent form. Prenatal interviews were conducted in the offices of the practitioners while postpartum interviews were conducted in a place convenient to the woman such as her home or office. Of the 80 women who participated in the prenatal interview, 63 (78%) chose to participate in the postpartum interview. The postpartum interviews explored the participants' birth experiences and maternal and infant outcomes. The interviews were digitally recorded and