Women and Birth xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

Women and Birth

journal homepage: www.elsevier.com/locate/wombi

DISCUSSION

Functional discomfort and a shift in midwifery paradigm

Ruth Sanders BSc, MA, BA*

Norfolk & Norwich University Hospital Trust, Registered Midwife (RM)

ARTICLE INFO

Article history:
Received 15 January 2015
Received in revised form 4 March 2015
Accepted 9 March 2015

Keywords:
Labour pain
Epidural analgesia
Midwifery facilitation
Functional discomfort
Birth

ABSTRACT

Objective: To determine and critically examine maternity attitudes surrounding labour pain and how midwives can best facilitate women navigating intrapartum discomfort without relying on 'pain-relief' strategies or immediate recourse for analgesic assistance.
Approach: This article examines current literature using seminal research and wider international perspectives, exploring the complex and fluctuating needs of women negotiating the composite factors of labour discomfort are investigated.
Findings: Factors such as birth environment, fear, midwifery presence, and self-efficacy, have a significant impact on the uptake of intrapartum analgesia. A holistic view of intrapartum discomfort is needed to shift the current paradigm of pathologising labour pain into one which situates it as a source of positive physiology and functional discomfort.
Conclusion: Continuing to practice with a pharmacological outlook, aiming to rid the labouring body of discomfort, is reductionist for both midwives and women. Midwives must seek to employ a new lexicon with which to communicate and facilitate women within the dynamic and continually changing territory of labour. If this conceptual shift is realised, the subsequent positive sequalae of women rediscovering their innate birthing capabilities could create a situation where birth can be considered as an aesthetic peak experience, improving satisfaction on both sides of the midwife-mother diad.

1. Introduction

Labour pain is complex and multi-dimensional, influenced by culture, media, social, ethnic and socio-demographic factors, demanding flexibility from midwives for women's successful journey through the landscape of labour as they advance towards motherhood. Current UK statistics show that only 50.7% of spontaneous birth occurs without anaesthetics,[1] with international rates mirroring this trend.[2] These statistics call for significant improvements in how midwifery professionals engage with labour pain. This paper explores how midwives can better facilitate women navigating discomfort during labour, acknowledging subsequent repercussions upon current practice and the reliance on pain relieving substances.

Midwives are centrally placed to alter behavioural patterns, which a new paradigm could enable, de-emphasising dependence on healthcare professionals to 'deliver' women from the labour pain experience; rather championing women's intrinsic ability to birth their babies normally and without analgesia.

This article explores possible repercussions of changing to a 'working-with pain' model,[3] identifying means to implement this in current practice. The correlation between positive midwifery support and lower rates of anaesthetic intervention deserves exploration, with physiological and psychological behaviours requiring assessment, both impacting the relationship to the discomfort experienced during labour. The use of a linguistic shift with midwives expressing labour as an experience of 'functional discomfort' rather than an inherently negative pain process, enables a paradigm change towards a more facilitative woman-centred and empowering stance in relation to physiological labour discomfort. It has been observed how supportive, continuous and contiguous midwifery care can empower women's self-belief, facilitating normal birth without pharmacological assistance. This is of key importance in the midwifery role having life altering repercussions for women, particularly with increasingly concerning rates of anaesthetic intervention.

2. The physiological key – pain: defining definition

Defined as 'an unpleasant sensory and/or emotional experience associated with actual or potential tissue damage'[4] pain as a term, provides a challenge within midwifery care, posing difficulties of

* Tel.: +44 07832 118445/1603 477232.
E-mail address: ruthalexsanders@gmail.com

http://dx.doi.org/10.1016/j.wombi.2015.03.001
1871-5192/

definition and perception on both personal and biological levels.[5] Fundamentally pathological, pain is associated with damage and suffering,[6,7] whereas discomfort during labour occurs as part of a normal physiological process. This differentiation between chronic pain, and the fluctuating discomfort experienced by women in labour is essential. Lowe states 'labour pain is not associated with pathology but with the most basic and fundamental of life's experiences'.[8] It could be argued that a new lexicon needs instigating in maternity settings to counteract these associations with pathology.

Dick-Read[9] suggests the sensations experienced in labour become "painful" because of their complexity, subjectivity and cultural associations, and if approached and negotiated differently this could be abated.

Rather than operating within the current systematic approach which either aims to eliminate the physical sensations of labour or regards it as a problem to be resolved; facilitative midwifery requires not only understanding the processes of how labour discomfort operates, but also effectively communicating those processes to, with and for parturients. Working with a psycho-physiological focus as undisturbed birth progresses, promoting the body to function normally, midwives have the potential to facilitate women's experience into a transformational one of functional discomfort, as opposed to enduring pain.

Rather than assisting in the anaesthetising of what is normal birth, discussing labour pain in terms of 'functional discomfort' rather than 'labour pain' and 'pain-relief' could allow for the broad range of intricacies in experience and perception, creating a break from pre-existing associations and the negative connotations therein. I would argue that the continued use of metaphor currently employed by the profession and in an attempt to describe the sensations of contractions by likening them to 'waves', 'rushes' or 'surges', in fact detracts from valid and accurate physiological information being given to women. The term contraction should be reclaimed for labour because this is physiologically accurate in describing the process of how the uterus functions during birth, and by giving women this important information of functionality it may be possible to enter more readily into the discomfort which accompanies the process rather than in opposition to it. If midwives do not reclaim the term then the message conveyed to women is one of avoidance, inferring that contractions are to be feared or resisted and inadvertently places women at a disadvantage in their ability to be able to engage with the activity of their own physiology. This is not to say that the sensations of labour are comfortable, but by using 'functional discomfort' the emphasis is shifted from a pathological pain framework in which women must passively tolerate challenging sensations, into a psychological recognition for their active involvement in the biophysical involuntary process of birth.

This paradigm shift has the potential for midwives to facilitate an aesthetic birth experience for the women in their care.

It must be acknowledged that the midwifery profession remains considerably under-funded and arguably undervalued within the realm of frontline practitioners. With a highly pressurised politically fraught working environment, in addition to an acute awareness of litigiously-focused practice, the wider culture in which most midwives currently work remains fettered by a deep managerial fear of enabling midwives to act as the autonomous practitioners their role allows. The political and systemic intransigence of ever expanding hospital size and the lack of continuity and relationship based care with a known care provider arguably create a milieu iatrogenic to autonomous midwifery practice. However in order to begin addressing this midwives must begin to further normalise labour in a setting which is fundamentally designed to deal with essentially pathological issues.

For the most part midwives operate in an institutional system advocating choice of pain-relieving substances available for women during labour. For birth to reside within the sphere of normality, midwives must challenge cultural and institutional ideologies surrounding labour discomfort.[10] Melzack & Wall's theory situates pain as a psycho-physiological process embedded in social and personal experience. Varying levels of discomfort operate as defining elements of labour; however the model pervading midwifery practice is one of a chronic or pathological pain in need of solution via intervention[11] focusing practice upon 'relieving'[12] any discomfort experienced. This alignment and association of labour pain with illness, creates a conjunction with suffering. The medical model proposes maternity as an illness or medical event needing technological interference with the whole childbearing process having what Raynor & England describe as 'the potential to malfunction'.[13] Downe & McCourt[14] argue that approaching childbirth from a pathological stance renders the benefits of physiological birth 'invisible'.

Continuing to use this model disregards the importance of intrapartum discomfort. The unique and subjective nature of this functional discomfort and its place in birth forms what Karlsdottir et al.[15] describe as a 'natural phenomenon' in childbearing, part of the salutogenic nature of normal birth, residing within the social model, generally considered holistic in essence, promoting birth as a biophysical event.

The cultural milieu and pervading ideologies of birth pain become compounded by representations found in the media. Television shows such as 'One Born Every Minute',[16] have the potential to be educational, but instead often depict birth as drama. This creates what journalists, including Williams[17] suggest as 'a struggle to make a case for [what is shown] as a purely realistic birth experience', Garrod[18] further highlighting that edited television programmes cannot represent the complex architecture of normal labour. Although some prospective parents may find reality television depictions reassuring, others may find them disturbing and fear inducing, with representations often showing birth as 'high risk', inevitably requiring intervention.[19]

These cultural tropes consolidate the existing paradigm of birth as technocratic,[20] objectifying the labouring body as one needing constant observation and surveillance, being 'unreliable and inferior'.[21] This influences how women view their own ability. This paradigm appears fundamentally flawed in its capacity to enable women to confidently function within the discomfort of labour, negating what midwives often work towards, that of labour facilitation. Changing the approach towards labour discomfort requires a renegotiation of terminology, with particular consideration to intrapartum communication, altering current terms to those arguably more beneficial to women. If midwives do not pursue this change in approach, women will continue to be predisposed by negative cultural and media representation, restricting their perceptions of self to a patient role, less able to cope during childbirth.[22]

Leap's influential work[3] suggests midwives currently use a 'menu' model, structured with non-pharmacological strategies followed by pharmacological analgesics in order of effectiveness, regarding discomfort suppression. Initial, expectant methods of management used at home, progress later in labour to interventionist relief, available once in a healthcare setting.[23] This pharmaco-centric 'ladder' approach[23] proposes a hierarchy of pain relief women can progress along as labour develops. This 'offering' model has been mooted as humanitarian and appropriate,[11] reinforcing midwifery practice within the scope of informed choice and consent.[24,25] However, while affording women to utilise what is offered, these offerings undermine women's endogenous resources implying that, at some point in their forthcoming labours, pharmacological assistance will be

Please cite this article in press as: Sanders R. Functional discomfort and a shift in midwifery paradigm. *Women Birth* (2015), http://dx.doi.org/10.1016/j.wombi.2015.03.001