University of Brighton

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Risks in childbirth in historical perspective

AHRC funded network

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Workshop 3:

Date: 6th July 2017

Venue: Room 101 Mayfield House, Falmer Campus, University of Brighton

time	session	speaker	Title
10:30	Arrival and coffee		
11:00		Emma Cheatle	**Building maternal materialism 1747–1830**
11:15		Salim Al-Gailani	**'Linking up expectant mothers with antenatal care': Public health and perceptions of risk in pregnancy in Britain, 1914-1936**
11:30		Angela Davis	**Ideas of risk in narratives of home birth: A study of South Wales c. 1948-1970**
11:45		Malcolm Nicolson	**Maternity and Technology – reflections from the history of obstetric ultrasound.**
12:00	Roundtable discussion		
12:45	Lunch		

13:30 13:45 14:00 14:15		Bernie Divall Kathleen Vongsathorn Magdalena Ohaja Lisa Hinton	**The evolution of birth plans: expressing preferences within a discourse of risk** **Picking the Message: Choosing the Risks and Benefits of Childbirth in Uganda, 1921-2017** **Cultural safety: construction of risk in the context of safe motherhood in Nigeria** **"Why wasn't I scared? I'm scared now" How mothers make sense of birth and near death.**
14:30	tea/coffee		
14:45	Roundtable discussion	Pre-circulated areas for debate	Language (normal, rare, unnatural, difficult etc) Tools and technology Mother and foetus And possibly something around cost; in its widest sense. So that would include finance, but possibly also social costs. perspectives
15:45	Next steps		Networks funding
16:30	close		

Abstracts:

Dr Emma Cheatle (Newcastle university)

The first births in England that occurred intentionally outside the home took place in the so called lying-in hospitals of the late 1740s. Proposed as philanthropic charities for 'the pregnant wives of the industrious poor' (Pyne and Combe, 1808: 134), contemporary research focusses on the lying-in hospital's provision of poor relief, and the accomplishments or mistakes of the man-midwives they were associated with, but not the buildings themselves. Although some of the hospitals occupied converted houses, many acquired grand purpose-made buildings; six were newly built in London alone between 1749–73. My research proposes a material, spatial history of lying-in, probing the hospital's role in changing the understanding of the maternal body. It is a history of divergence, opposition and overlap between spaces and bodies (home/institution, public/private, tradition/experimentation, safety/risk and masculine/feminine). Where the home was the 'given', unquestioned space for birth until the lying-in hospital, the latter was modelled on medical, asylum and ecclesiastical institutions, in contestation to the domestic environment. Each lying-in building was instituted by an ambitious man-midwife, providing him a formal space for medical experiment, including instrumental intervention and autopsy. The hospitals were welcome to women with poor domestic conditions, but conversely offered a compromised, even dangerous, spatial experience. Further, as the risk of death in hospital rose throughout the eighteenth century (Loudon, 1992: 13–17), the man-midwife's opportunities for dissection increased, shifting the material understanding of the female body.

There are few extant lying-in hospitals and their contents have long disappeared. My research instead draws on a range of visual and textual archival materials – namely drawings, architectural plans, and literary descriptions of spaces from midwifery manuals, diaries and novels. In this paper, I use these to present accounts of first, the lying-in chamber of the early eighteenth-century home, then, of the newly built City of London Lying-in Hospital, 1773. I evaluate the way their different spatial and material qualities (light and air, size, scale, location in the city; objects, decorations and furniture), paralleled and instigated a new material understanding of both the body of the birthing women and her home as a traditional space for delivery.

Salim Al-Gailani (University of Cambridge)

This paper examines debates over the various strategies adopted by service providers to encourage prospective mothers to seek 'antenatal care' in Britain between World War One and the Midwives Act of 1936. Amid wider efforts to improve healthcare provision for mothers and babies, public health officials mooted the prospect of making pregnancy a notifiable condition, like some infectious diseases. Although officially frowned upon for both ethical and practical reasons, 'notification of pregnancy' schemes were introduced in various guises by a number of local authorities from 1916. In adopting positions for or against notification, midwives, GPs and Medical Officers promoted different views of the risks associated with pregnancy, and how best to manage them. Studying the controversy helps to appreciate the contested process through which antenatal care was integrated into maternity and infant welfare.

Angela Davis (University of Warwick) **/ Billie Hunter** (University of Cardiff) **/ Kate Boyer**
Over the past seventy years, the culturally accepted place of birth in England and Wales has shifted dramatically. Before the Second World War, most births were at home. However, a gradual trend towards hospital birth was in progress; selection criteria for hospital birth were broadened and consultant bed numbers increased (Hunter 2013). By the mid-1960s, two-thirds of births were in hospital (Davis 2013). The 1970 Peel Report compounded this change, recommending provision for 100% hospital births. Since 1975 the hospital birth rate has never fallen below 95% (Davis 2013). While attitudes to place of birth continue to change - recent evidence from the *Birthplace in England* study demonstrating the safety of out-of-hospital births for low-risk women has been endorsed by updated NICE intrapartum guidelines (Delgado Nunes et al 2014) – the numbers of birth taking place at home remain very small. In this paper we will look at how this move to hospital birth influenced the ways in which mothers, midwives and doctors thought about home birth. Based on interviews with 14 respondents (6 mothers, 6 midwives and 2 doctors) who lived or practised in South Wales between 1948 and 1970, the paper will analyse the ways in which risk in homebirth were articulated by each group, and between the different individuals within these groups. We will consider what the risks of giving birth at home were considered to be, whether they were changing over the period, and how the portrayal of risk in mothers' and professionals' stories of home birth compared with accounts of risk in hospital birth. We will also examine whether recent changes in attitudes towards home birth have led people to reappraise their previous positions. While demonstrating the multiple understandings of risk people held, we will posit that, despite their different attitudes towards and experiences of home birth, risk become a common trope of narratives of home birth at this time

Malcolm Nicolson (University of Glasgow)
The paper will examine attitudes to the safety and utility of obstetric ultrasound. In the early years of the technology's deployment, concerns were regularly raised about the safety of the ultrasonic scanner. And in some circles they still are. It will be argued that, millions of fetuses having been insonated *in utero* and with no convincing evidence of harm having been found, it reasonable to conclude that the pulse-echo modality of diagnostic ultrasound is safe, at least in the manner it has so far been employed for diagnostic purposes. However, it will also be argued that we should not be complacent on the matter of safety. Indeed, I would welcome a more informed debate on the question of power outputs.
Having said that, it is hard to take many of the anxieties regarding the safety of ultrasound entirely at face value. The role played by the issue of the risks of ultrasound scanning in the feminist critique of obstetrics would seem to be a symbolic one. Raising the possibility of danger has allowed the expression of deeper disquiets about the encroachment of technology into the realms of pregnancy and birth, concerns which found a particular focus in the ultrasound scanner as both a major agent for, and a potent symbol of, the medicalisation of childbirth. Nevertheless activist women currently of child bearing age generally have a more positive attitude to ultrasound than their predecessors of the previous generation. The paper will examine changing attitudes to the ultrasound image, both medical and feminist.

Bernie Divall (University of Nottingham)
Formal, written birth plans were introduced in the 1980s as an attempt by women to gain a sense of control over the childbirth experience, and by childbirth educators to help women avoid escalating

interventions. Birth plans have since been incorporated into antenatal and intrapartum care provision in the NHS. Many NHS organisations provide explicit guidance and space for the completion of birth plans in women's maternity notes, and there is a vast amount of information for parents available on the Internet. Furthermore, both the Department of Health and the National Institute for Health and Care Excellence advocate the use of birth plans, where they are framed as part of a commitment to individualised care and associated with the involvement of women in their own care, information giving by healthcare professionals, the establishment of effective communication between women and their caregivers, and a means by which women are able to maintain a sense of control during childbirth.
This presentation offers an exploration of the concept of risk in the context of discourses around birth plans, from the perspective of healthcare professionals and women. Through the examination of two birth plan templates, produced thirty years apart, and analysis of the views of healthcare professionals and women across this time span, I discuss how birth plans can be seen to represent norms and expectations in labour and birth, and in what ways the discourse of risk has impacted on the content and structure of birth plan templates over time.

Kathleen Vongsathorn (University of Warwick)
In present-day Uganda, forty-seven percent of women give birth without 'skilled' medical attendance, which is linked to a high maternal mortality rate that has decreased very little over the past thirty years. Part of a wider project on the spread and adaptation of biomedical knowledge in Uganda between 1897 and 1979, this paper will explore women's engagement with maternity services over the last century in Uganda, as a means of understanding why women have, in the past and the present, chosen to engage with or avoid biomedical facilities for childbirth, and how that choice relates to their perception of the risks of childbirth.

There are a variety of reasons that so many Ugandan women give birth without a biomedical professional attendance, but significant among them is many women's – or their relatives' – reluctance to deliver in health centres. While health education has increased women's awareness of the risks that home deliveries might pose to their lives or the lives of their babies if they deliver at home ('skilled' attendance being available for home deliveries only in very exceptional circumstances), women continue to perceive other risks to childbirth in a hospital, including physical and verbal abuse from medical staff, surgical interventions perceived unnecessary, and practices of handling childbirth that endanger the future social health of the mother or child. Drawing on interviews with midwives, traditional birth attendants, and community members in Uganda, and on hospital, mission, and government records, this paper will discuss how individuals and families have chosen whether to give birth in the village or in biomedical facilities based on their perceptions of the risk and benefits attached to each option, rather than because of their ignorance of the risks involved in home delivery, as many medical professionals in Uganda have long attested.

Magdalena Ohaja (Trinity College, Dublin)
Background: The tension between medical (modern) and lay (traditional) perspectives about risk as it relates to childbirth has commanded continuing attention in recent years. The medical construction of risk has had the upper hand in western countries, and is a trajectory that is now common in non-western countries including Nigeria. This has resulted in the colonisation of pregnant and birthing bodies within a culture of medicalisation embedded in formal health services

in Nigeria. However, given the plurality of pregnancy and birth practices in Nigeria, a local birth culture has not been completely absorbed by this culture of medicalisation.
Methodology: This paper is drawn from a study that explored the concept of safe motherhood from women and birth practitioners (midwives and traditional birth attendants) in southeast Nigeria. The study used both hermeneutic phenomenological and poststructural feminist approaches. Individual face to face interview were used to ascertain the participants' perspectives.
Findings: The 'use of traditional medicine,' and 'normal birth' are considered safe by the participants who by extension express an 'aversion to caesarean section' while interventions including 'instrumental births' and 'too much drugs' were described as unsafe (risky). The uptake and choice of maternity care by women, particularly those in rural areas, is informed by their socio-cultural beliefs. As such, the study explores the extent to which safety and risk are socially and culturally constructed.
Conclusion: Cultural safety is neglected in medical risk/safety discourse. Conceptualising pregnancy and birth within the belief system(s) of a given society is critical for a deeper understanding of what constitutes safety and risk within that society. In other words, risk and safety cannot be discussed in isolation of the context (indigenous paradigm), a mistake made by some of the international advocates of hospital-based maternity care for so long.

Lisa Hinton (University of Oxford)
Giving birth in developed countries is now safer than ever. Yet thousands of women a year still develop life-threatening illness during pregnancy or childbirth. These experiences are unanticipated and run counter to common narratives of safe, normal childbirth.

This paper will explore how women make sense of life threatening illness in childbirth, reporting on a detailed narrative analysis of a sub-set of 50 interviews conducted with women and partners in the UK (2010-2014) as part of a study of women's experiences of near-miss maternal morbidity (women who survived life threatening conditions such as pre-eclampsia, post-partum haemorrhage, sepsis or placental abruption).

This paper will ask "How sense is made/stories are told in the narrators attempt to rewrite their life stories" against the backdrop of contemporary narratives of what constitutes a "good birth" and a "safe birth". Most women who experience a life-threatening event in childbirth have no warning of their illness. They suddenly find themselves in receipt of traumatic emergency treatment, often being cared for in intensive care units, and separated from their newborn. The journey to new motherhood is dramatically interrupted. As they recover and start to make sense to their near-death experience, they often feel they have failed to achieve a good or normal birth, while struggling to come to terms with new parenthood and recovery from serious illness. How do women tell broken narratives of traumatic illness as they seek to establish new narratives around motherhood and new life?

Keywords: pregnancy, life-threatening illness, childbirth, trauma, narrative

Participants			
Salim Al-Gailani	history	University of Cambridge	ssa32@cam.ac.uk
Dr Janette Allotey	Midwifery/ history	Manchester University	alloteyjanette@gmail.com
Dr Cathy Ashwin	Editor MIDIRS	MIDIRS	Cathy.ashwin@midirs.org
Dr Emma Cheatle	Architecture	Newcastle University	emma.cheatle@ncl.ac.uk
Dr Angela Davis	history	University of Warwick	Angela.davis@warwick.ac.uk
Dr Isabel Davis	Medieval and renaissance literature	Birkbeck University	drbeldavis@gmail.com
Dr Bernie Divall	midwifery	University of Nottingham	Bernadette.Divall@nottingham.ac.uk
Margaret Dunlea	midwifery	Trinity College, Dublin	dunleama@tcd.ie
Dr Lisa Hinton	Medical sociologist	University of Oxford	Lisa.hinton@phc.ox.ac.uk
Professor Billie Hunter	Midwifery/ history	Cardiff University	HunterB1@cardiff.ac.uk
Professor Helen King	classics	Open University	helen.king@open.ac.uk
Professor Christine McCourt	anthropology	City University	Christine.mccourt.1@city.ac.uk
Dr Elselijn Kingma	Philosophy	Southampton University	E.M.Kingma@soton.ac.uk
Dr Tania McIntosh	Midwifery/ history	Brighton University	t.mcintosh@brighton.ac.uk
Gemma Newby	Radio producer		gemnewby@googlemail.com
Malcolm Nicolson	History of medicine	University of Glasgow	Malcolm.nicolson@glasgow.ac.uk
Magdalena Ohaja	Midwifery	Trinity College, Dublin	ohajam@tcd.ie
Lauren Ryall Stockton	Curator	Thackray Museum, Leeds	lauren@thackraymuseum.org
Kathleen Vongsathorn	history	University of Warwick	K.vongsathorn@warwick.ac.uk
Jo White	anthropology	University of West of England	jo.white@uwe.ac.uk
Dr Adrian Wilson	history	Leeds University	A.F.Wilson@leeds.ac.uk