New Beginnings
DOULA TRAINING

Early Labour and Mixed Messages

Posted on September 22, 2012 by midwifethinking (used with permission)

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Edited and updated: November 2013

This post is about early labour and the mixed messages women are given about this important part of the birthing process.

Defining the indefinable

The concept of 'early' or 'latent' labour emerged as a result of the birth process being broken down into stage and phases – the diagnosis of which relies on clinical assessments of contraction pattern and cervical dilatation. The notion of being able to determine the future progress of labour from such clinical assessments is not supported by research, yet it underpins maternity care. What research does show is that concepts of stages and phases of labour does not align with women's perception and assessment of their own birth process (Gross et al. 2009; Low & Moffat 2006; Dixon et al. 2012).

In addition 'early' is only 'early' with hindsight. At one point in time (the clinical diagnosis of early labour) there is no way of knowing if labour will result in a baby in 30 minutes or 24 hours. If a labour is 2 hours long… when did early labour occur? As previously discussed an individual woman's body is unique and so is her labour pattern.

Labour is basically the process by which a baby moves from the inside of a woman to the outside of a woman. Sounds simple, but it is incredibly complex and involves a complicated interplay of physiological, psychological and emotional factors. Women's experience of labour often involves a sense of separation from the external world, focusing within, and becoming immersed in the act

of giving birth. The hormones released during birth support this 'altered state of consciousness' (see the work of Sarah Buckley). During early labour the woman is beginning to move into this birthing state. Many midwives, including myself use the changes in behaviour displayed by women as they move into, and through the 'birthing state' to estimate how close the birth is. Of course, just like clinical assessments this is not entirely reliable as some women do not follow the usual scenario.

Despite the fact that concepts such as 'early labour' and 'established labour' are constructed, and not very helpful… I need to use these terms in this post because they are used consistently in the literature I am discussing (apologies).

Hospital perspective: early labourers are not welcome

Women admitted to hospital in early labour are more likely to end up experiencing complications and interventions, including caesarean section (Klein et al. 2004; Bailit et al. 2009; Rahnama et al. 2006). There are two explanations for this:

1. That these women already have a dysfunctional, prolonged labour which is why they are coming to hospital in early labour. This explanation is favoured by a local hospital, and their response is to augment (ARM and IV syntocinon) all women who are admitted in early labour who do not establish labour within 2 hours. The rationale is to avoid a prolonged, complicated labour… and according to the obstetrician 'women don't want to be in labour for a long time'. I wonder if the women are consenting to these procedures based on

adequate information… or just being asked if they want a shorter labour (hands up!)
2. That exposure to the routine interventions involved with care in a hospital setting increase the chance of complications occurring (Bailit et al. 2009) ie,. the longer the woman is in the system, the more opportunity there is to 'do stuff' to her.

Women admitted to hospital in early labour also cost the institution more money because they are on the ward for longer which increases demands on services and staffing. Therefore, great efforts are made to deter women from settling themselves into hospital during early labour. Antenatal classes warn women to stay away from the hospital for as long as possible to avoid intervention. When women ring the hospital to enquire about coming in, they are advised to "take a paracetamol, have a bath then ring back in an hour" (guilty). Women are also told to only come to hospital when their contractions are coming every 5 minutes or less – which is concerning because the pattern of contractions is not necessarily an indicator of when the baby will be born. Entire services have been devised (phone support/home visits) to support women to stay at home during early labour (Janssen et al. 2009). When women arrive at hospital they are subjected to invasive clinical assessments to diagnose 'established labour' before they are 'cleared' for admission to labour ward (Cheyne et al. 2008).

If a woman does manage to get admitted whilst in early labour she is considered a burden by staff. She is likely to be put in a room and checked on occasionally and referred to as 'not doing anything', 'niggling', 'she should go home', etc. The midwife who admits her

will be questioned and ridiculed at handover. The midwife allocated to her will most likely also be caring for a woman in 'real labour', and that woman will take priority. This is not to bag hospital midwives… I've been there myself, and it is very frustrating dealing with a woman in early labour whilst also caring for 1 or more women in 'advanced' labour. Whilst not condoning the hospital perspective on early labour – I can understand it from a cost/staffing perspective.

Women's perspective: seeking reassurance and safety

Findings from qualitative studies suggest that staying away from hospital during early labour can be challenging for women. It seems that women want to be in hospital. And the experience of being assessed as 'not in labour' and sent home can be distressing and result in women feeling unsupported (Baxter 2007; Barnett et al. 2008; Scotland et al. 2011). A study of first time mothers found that women experienced embarrassment when they arrived at hospital too early to stay (Eri et al. 2010). They also felt vulnerable when negotiating with midwives to stay. The need to be in hospital is not necessarily about needing pain relief or support. Cheyne et al. (2007) found that women wanted to be in hospital during early labour despite feeling that they were coping well at home. Some participants reported feeling uncertainty about the safety of their baby whilst at home. Carlsson et al. (2009) also found that women were concerned for the wellbeing of themselves and their baby whilst labouring at home. They identified the theme 'handing over responsibility' as the core category emerging from their data. Women were keen to transfer to hospital in order to hand over the responsibility for safety to midwives.

Another concern associated with staying at home during early labour is uncertainty about identifying when established labour begins. Women in Cheyne et al.'s (2007) study expressed concern about not knowing how advanced their labour was while at home. Beebe et al. (2006) also found that first time mothers struggled to identify the onset of active labour themselves. Women worried about going to hospital too soon or too late, and were unsure of how to know if their labour was 'the real thing'. Their main concern about staying at home was not being able to have their labour assessed by hospital staff. In Eri et al.'s (2010) study women perceived midwives as 'gatekeepers' with whom they had to negotiate their credibility with in order to gain access to the hospital. Gross et al. (2009) found that women's own assessment of how and when their labour began was varied and did not match midwives' clinical diagnosis of labour onset. A study of first time mothers by Low and Moffat (2006) found that women were perceived as abnormal by hospital staff if their experience of labour onset did not fit clinical definitions. Themes identified from the data included 'this is not right' and 'don't trust your body, trust us'

Physiology and contradictory messages

Let's take a look at physiological explanations for early labour behaviour. Like all other mammals, labouring women seek a private and safe place where they can avoid distraction and immerse themselves in the act of birthing. During early labour women seek a place to settle and 'nest'. This makes perfect sense because the neocortex is still engaged and can slow contractions (by reducing oxytocin) in response to thinking, talking, etc. – the

woman can think clearly and do the practical things involved in a physical move. Once the woman is settled and her neocortex is not being stimulated, increased oxytocin release re-establishes contractions. This explains why labour often slows down in response to the move to hospital. However, as labour progresses the limbic system takes over and it becomes more difficult – and dangerous from an evolutionary perspective – to move from place to place. The neocortex is suppressed and the woman is deeply in an altered state of consciousness. This is the women who arrives at hospital already 'separated' from the external world, nothing stops her contractions, and she is often unaware of those around her until after the birth. So, the need to settle into the birth place during early labour is a normal response to the physiology of the birth process. It is also common for women to call on the support of other women during labour – women they know and who they feel safe with – relatives, friends, midwives, doulas. *Early labour is a woman's signal to get settled somewhere safe and to gather her 'women-folk' around her.*

What is considered a 'safe place' is influenced by the culture in which the birth is taking place. I am not getting into the debate of hospital vs home re. safety. One, because I am totally over it, and two because I am a slightly biased homebirth midwife. Here is a Cochrane Review if you feel the need to head into the debate. Women in Australia (and many other parts of the world) are urged to birth in hospital because the cultural concepts of 'safe' involve medicine and technology. The experts in birth are the people who know how to use the medicine and technology, and who can carry out clinical assessments to determine wellness and progress (Davis-Floyd 2003). This message begins in pregnancy as

women undergo routine clinical assessments with an emphasis on professional experts providing reassurance of wellbeing. Women are also bombarded with fear-based media about the dangers of birth, and the hospital-based Knights in Shining Armour who will gladly rescue any Damsel in Distress (and her baby). Therefore, it is not surprising that women head for the safety of the hospital when they are in early labour. Our culture has replaced the home/birth hut + well known women-folk with the hospital + unknown medical staff.

The emphasis on hospital as a place of safety whilst also encouraging women to stay away results in some very contradictory messages and ideas (please note these statements do not represent my own views):

- We are the experts in your labour progress, only our clinical assessments can determine what is happening… but we'd rather you do not come in to be assessed, and instead stay at home not knowing what is going on.
- Trust us – we want you to have a good birth experience… but if you come in too early we are likely to create complications which will require intervention… so keep away from us as long as you can.
- We are the experts in your labour progress, our clinical assessments can predict your future labour progress… we will send you home if you are found to be in early labour… if you then birth your baby in the car park it is not our fault as birth is unpredictable.
- This is a safe place to labour…. but you can only access this safety when you reach a particular point in your labour…

preferably close to the end of your labour i.e. you should do most of it on your own away from safety. This contradiction results in a very annoying double standard: A women who labours at home and comes into hospital 'fully and pushing' is praised – 'she did a great job'. However, she laboured (perhaps for many hours) without the attendance of a professional and without any monitoring (eg. fetal heart rate auscultation, etc.)…. On the other hand, a woman who homebirths intentionally is considered to be doing something unsafe despite the constant attendance and monitoring of her midwife.

Suggestions

Rather than considering 'how to prevent women in early labour being admitted to hospital', instead it may be better to explore how women's needs during early labour can be accommodated by the maternity system. I would be interested to know what your experiences and/or suggestions are. Here are some thoughts, as usual I'm ignoring constraints of the system and money in favour of fantasy:

- Antenatal care should centre on building self-trust and reinforcing the woman's own expertise in birthing her baby. If she relies on herself to determine wellbeing and progress she may be less likely to head to hospital early for reassurance. A study by Carlsson et al. (2012) found that first time mothers who managed to remain at home during early labour expressed a sense of power. Maintaining power was the central focus for these women and involved a sense of authority over their own body. Something to be encouraged I

think!

- Give early labour respect. It is an important part of the birth process and women deserve recognition for it… ie. don't use the term 'latent' or 'not in established labour'. The woman has begun the birth process. She has her signal to seek a safe place – help her do this.
- Women's access to their birth space should not rely on them meeting arbitrary measurements which involve invasive clinical assessments. They should be able to use early labour to get to their 'safe place' and settle for birth.
- If you are planning to head to hospital while deeply in the altered state of labour – it might be useful to take along a doula who can advocate and use her neocortex while yours is suppressed.

Of course if a woman is birthing at home with a known and trusted midwife it is a different kettle of fish. She doesn't need to concern herself with 'when to go to hospital' – and her midwife can (should) attend based on when the woman needs her… not when she meets particular criteria. Then again in the real world not all women want to birth at home, or can get the support to do so. Therefore, the systems in which they birth need to change. The essential problem is that maternity care has developed in response to the needs of institutions – not the needs of women. More research is being done… and reports published about what women want from their maternity system. Unfortunately what they want (woman-centred, continuity of care) is the opposite to what is already deeply embedded in our society (hospital-based, fragmented care). To

turn this around is a huge undertaking… and change will undoubtedly meet resistance from those who benefit from the way things are.

Posted on September 14, 2011 by midwifethinking (reprinted with permission)