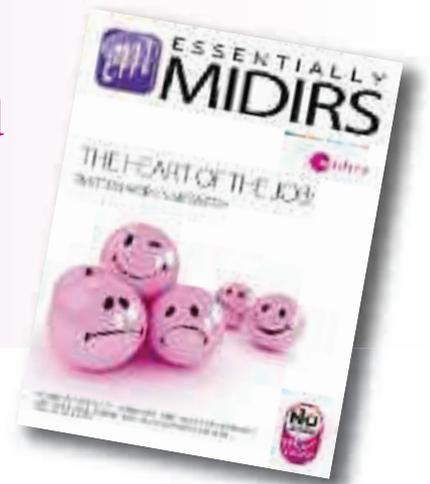




Editorial comment on issues addressed in this month's Essentially MIDIRS...

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Comment by
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Normality and goalposts

This month, I was particularly interested to read a couple of the studies that have been included in MIDIRS Update: those by Mackenzie *et al* (2010) on normal urine output after elective caesarean section and Montgomery-Downs *et al* (2010) on normative longitudinal sleep in the first four months of the postpartum period.

Both set out to better understand what 'normal' looks like in particular areas. Both also note that this is not already well understood (which is key when we consider that the decision about whether something is normal or otherwise can have massive implications for women and babies), and the findings of such research enable us to further reflect upon the concept of normality, an area much-debated within midwifery and further

afield. As Holly Powell-Kennedy pointed out recently

"normal," as it pertains to childbirth, is problematic. Normal is defined as "regular, usual, typical, ordinary, and conventional; physically and mentally sound; free from any disorder; healthy." It is a word that dichotomizes—if you are not "normal," then you must be abnormal, atypical, disordered, unhealthy, or irregular—and who wants those labels?" (Powell-Kennedy 2010:199).

Holly's commentary highlights the problem that arises when we create goalposts – or markers around what we consider normal. The creation of a space which is determined to be normal (or, to continue using the metaphor, the goal) necessarily and unavoidably creates another space (everywhere except the goal) which is, for whatever reason, deemed to be NOT normal.

Yet there is a vast difference between the use of a goal in, well, say football, and the use of a similar kind of defined space in relation to birth. I can't imagine that many Premiership referees would support a petition for goalposts which are individually flexible depending on the team, yet the need for flexibility is often debated when we consider the definition of what is normal in birth. The defining of normal space itself is probably inescapable, however. Although many people have questioned the usefulness of the population-level goalposts that are an inevitable feature of systems of maternity care where guidelines and shared understandings are a necessary means of maintaining order, even those midwives who work autonomously and outside of systemic guidelines need to have criteria for determining whether a woman's experience is normal or otherwise. Thus studies such as the ones mentioned above are vital, especially



as we have little understanding of what normal really looks like in some areas.

Flexibility in this area is key for a number of reasons, not least of which is the fact that normal can encompass a vast range and vary amongst different people. For instance, one of the first things that a woman and a midwife will talk about is the date on which the baby might be born, and even in an age where most women end up having their due date determined by technology, this still usually entails a conversation about the woman's last menstrual period. One of the questions frequently asked by midwives is whether this last menstrual period was a normal one, and we ask this in order to determine (among other things) whether it was actually a menstrual period or whether it might have been an implantation bleed. A midwife who I interviewed about this topic a few years ago said that, when asking women whether their last period was a normal one, she also asked each woman to describe what a normal period was like for her. Not, she stressed, because she felt she knew better and would go on to tell the woman that her idea of normal was incorrect, but because she had learned over the years that women have such a vast range of bodily experiences at this time and that it was easy for midwives to make erroneous assumptions about what the concept of normal means to women.

In one of the studies mentioned above, Mackenzie *et al* (2010) recognised that, while it is deemed important in practice to monitor women's urine output after caesarean section because of the potential for this surgery to interfere with women's physiology, no-one really had any evidence that could help them decide what was normal after such surgery. The goalposts were either non-existent or they were determined by individual practitioners (who, like it or not, are the equivalent of referees in this metaphor) on the basis of experience which may or may not be representative. Mackenzie *et al*'s (2010) study thus set out to attempt to determine the location of the goalposts and found, even in a small sample of women, that the range of experiences was wide.

Montgomery-Downs *et al*'s (2010) findings are equally interesting, albeit for different reasons. While the authors of this study acknowledge the difficulty in measuring every aspect of women's sleep, their findings suggest that women with new babies spend more time sleeping than we might think. This sleep, however, is highly fragmented. Fragmentation is an important feature of sleep which is increasingly recognised as being key to a



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person's well-being. These results also relate to another key aspect of the normality debate: in order to be helpful, we need to be measuring and monitoring the right elements of women's experiences. If we accept the findings of this study, for instance, they suggest that it may be more useful to focus on the quality of a woman's sleep; something which needs to be determined in part by the woman herself. Which is interesting, because, in modern culture, the power to define normal has generally lain firmly in the hands of the professional referee. Perhaps such findings can help provide a springboard for us to further explore how women can engage in defining and determining normality with us, in a way which is flexible, which acknowledges the range that exists in nature and which draws upon the useful aspects of this notion without causing women unnecessary stress and intervention when missing the goal incurs an unwarranted penalty.



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