Hands-off midwifery and the art of balance

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“You work with some midwives who do everything; they do VEs every four hours and have their hands doing all these things when the baby comes. And then you go out with others who are different, who hardly ever do those things, who just know where women are [in relation to the progress of their labour] by looking at them and listening and they don’t interfere so much; they seem to know when they really need to touch and when it’s better not to. And you think, ‘that’s great, that’s what I want to do!’ But how do I learn when to do it and not?” Kiera, Student Midwife

Introduction

A wide variety of ideological positions and practical trends have characterised approaches to health and birth throughout history. Early European medicine, for example, featured the theory of ‘humors’, which healers attempted to rebalance with the use of cathartics, purgatives and bleeding. Later, Western medicine was revolutionised by the work of people like Semmelweis and Lister, whose work on germ theory and antisepsis increased our understanding around how to prevent the transmission of disease. From this foundation, and through the development of bacteriology, vaccination, pharmacology and surgical techniques, the principles of Western medicine expanded and gained a firm footing as the dominant approach to healing in the industrialised world. Although a large number of other approaches to conceptualising, diagnosing and treating health and disease still exist, the principles behind Western medicine have continued to gain momentum and, as midwives know only too well, have more recently been applied to the care of women in childbirth as well as in the care of sick people.

The application of these principles to pregnancy and childbirth has not, of course, been universally popular. The past few decades have been characterised both by increased medicalisation of pregnancy and birth and by a significant degree of resistance to this from a number of groups and movements who do not consider it appropriate or useful. Perhaps inevitably, the exact nature and form of these movements varies geographically. New Zealand has a unique story of midwifery autonomy, while slightly differing stories have played out in Australia, the US, Canada, the UK and other countries. The trend towards the kind of hands-off approach which Kiera discusses above, however, can now be found in midwifery practice in all of these countries - and others - and it is this trend and some of the questions it raises for us as midwives that I would like to explore in this article.

What is Hands-Off Practice?

There does not seem to be a clear theoretical definition of what ‘hands-off’ practice means, although it is a term whose meaning might seem fairly obvious to most people. In relation to midwifery, it appears to be used in at least two ways. Firstly, it describes a general attitude; a low-tech and individualised approach where the practitioner does not manually intervene unless there is a both genuine need to do so and genuine consent has been obtained from the woman. This contrasts with the approach taken where systems of care and individual practitioners adopt routine practices or interventions which are then applied to all women on a population basis, rather than according to individual need or choice.

Secondly, the term ‘hands-off’ is used specifically in relation to a number of different aspects of midwifery practice, including:

- An approach to facilitating breech birth which involves careful watching, waiting and manual intervention only as appropriate, rather than the medical approach to “delivering” the breech baby through a series of relatively standardised manual interventions while the woman lies in a lithotomy or semi-recumbent position.

- An approach to attending women in labour such as that described in Lesley Dixon’s research, which recognises that vaginal examinations can be both traumatic and problematic for women and involves undertaking these only when truly indicated, rather than at regular and / or pre-defined, intervals.

- An approach to attending the birth of a baby where the midwife will not automatically place her hands in a particular series of positions on the baby’s head (and possibly the woman’s
perineum) and attempt to assist flexion and guide the birth in a relatively standardised way, but instead may either hold her hands ‘poised’ (as described by Rona McCandlish and colleagues”) and use them only if she perceives a particular need to do so, or will adapt her practice depending on the situation.

○ An approach where the midwife helps the mother to learn to breastfeed her baby without using her own hands to position and latch the baby on her mother’s breast”, thus enhancing the woman’s self-confidence in her ability to do this when the midwife is not able to be physically there to help her.

Each of these examples - and, indeed, the notion of being hands-off in general - illustrates a philosophy which I would suggest has arisen partly in opposition to the medicalised, intervention-heavy approach that has come under criticism from so many sources. I have heard a number of people speaking about how the roots of this approach may also lie in related, woman-centred trends such as the use of water for labour and birth, which render the midwife less able to carry out hand manoeuvres and thus place her in a position where she is able to extend her own comfort zones around the need to be hands-on. These notions are supported by a body of research evidence, and by documents such as the WHO Principles of Perinatal Care, which states that, “...care should be based on the use of appropriate technology ... reducing the overuse of technology or the application of sophisticated or complex technology where simpler procedures may suffice or indeed be simpler.”

Hands-Off - A Personal Perspective

I should probably declare a vested interest in this topic sooner rather than later; I would consider myself a hands-off midwife; although, like many of my colleagues who espouse this philosophy, I don’t hesitate to ask for permission to use my hands or other tools when I feel the situation genuinely calls for it. For example, I attend breech births with a ‘hands off the breech’ philosophy, yet at some point I have, with permission, used almost every one of the manual manoeuvres known to midwife-kind when I have felt they were truly warranted. As Ina May Gaskin often says, there is a danger that mantras such as ‘hands off the breech’, if used on their own, can mean that we risk taking the hands-off approach too far and end up with sub-optimal outcomes.

Many of the hands-off midwives that I have worked with and interviewed seek to use intervention appropriately rather than never at all. In a situation where performing a vaginal examination could lead to the gathering of information which could be truly useful and which cannot be gained any other way, midwives will discuss this option with the woman rather than ploughing on (but with their hands still off). Very few women decline intervention when they are in circumstances which truly warrant it and many of those midwives who take a hands-off approach embrace the (admittedly paradoxical) notions that one should never say always and never say never.

Instead of being an absolute rule, then, the hands-off approach for the midwives who practise this way seems to be the starting point from which the woman and midwife might decide to add in certain hands-on practices as and when they are deemed appropriate. This contrasts fairly starkly with the medicalised approach where the starting point involves regular manual, technological and pharmaceutical interventions which are only omitted if the woman particularly requests not to have them. The cornerstone of the practice of hands-off midwifery doesn’t seem to be about never using manual intervention, but about striving to achieve the art of balance within the context of ensuring that the promotion of women’s agency remains uppermost.

When Is Appropriate?

I discussed the question of how we can try to teach this balance with a group of midwives who define themselves as ‘hands-off, and we decided that, as a rough guide, an intervention should be contemplated when the midwife and woman both agree that it is really necessary, because either:

a) There is a real concern that there may be a problem, and the intervention (which includes screening tests like vaginal examination) could give further information about whether this problem exists or not, or

b) The woman is in a situation where the outcome of a test (like vaginal examination) or manoeuvre might impact upon an important decision (such as the decision to transfer from home to hospital in labour), or

c) The outcome of an action (like helping a breech baby to birth) is more likely to change the outcome of the situation for the better.
that it is to create problems, increase risk or lead to an unacceptable degree of discomfort for the woman and / or baby.

Again, the key issue seems to be about weighing up the risks and benefits of any (and each) intervention on an individual basis, which surely is what we are all striving to do in the aim of offering individually-tailored and sensitive midwifery care?

Exploring the Challenges...

I do wonder whether the misunderstanding that may arise where we use terms like ‘hands-off’ when we actually mean ‘hands-off unless there is a real need to put hands on’ means that we should re-think the terminology we are using here. Given the value that some women place upon this approach and the growing realisation amongst health care practitioners that women’s agency is paramount, it is likely to continue to be a feature of the ever-increasing autonomy of women and midwives. Indeed, in areas where this kind of care is not an option, more and more women are voting with their feet for a totally hands-off approach by choosing unassisted birth.

However, if we believe that the hands-off practice movement is an important part of the development of twenty-first century midwifery practice, there are a number of questions that need consideration. Among them are the vital matters of how we learn, teach and expand our understanding of hands-off practice, in order that this approach remains central to the needs of women and babies.

Kiera’s words at the beginning of this article illustrate the situation which has arisen where a good number of the midwives who have been at the forefront of developing the hands-off approach were already experienced in a more hands-on approach first. Some of these midwives’ practice is rooted in a deep kind of experiential knowledge that Kiera and many of her colleagues are now attempting to gain. Several of the midwives I have interviewed about their knowledge and practice over the years initially learned to perform intervention on a more regular basis. They then gradually expanded their trust of birth and their own comfort zones to a point where they felt able to do less and less and to downsize from a more medical approach as their experience and knowledge grew. As such, they have a great deal of experience upon which to draw; not only in the assessment of when intervention is truly warranted, but in having used these interventions enough in the past to perform them with skill and dexterity when they are needed. For me, this juxtaposition of the experienced midwife who has grown into the hands-off approach over time with the new midwife who so desperately wants to learn to work this way from the outset but who does not yet, in her own words, have the confidence to wholly do this, illustrates one of the very real challenges which has arisen as a result of the increased autonomy that women and midwives have gained.

Other challenges raised by this movement include the questions of how we develop and share individual and collective knowledge around this kind of practice, based as it is on a midwifery model rather than a medical model approach; and I am currently researching this very question. Perhaps even more important is the question of how we find safe ways in which we can openly discuss these issues - and review our practice - without falling prey to unwarranted criticism from outside, particularly from those groups who do not (for whatever reason) feel able to take an open and honest approach to the evaluation of their own practice.

Finding Answers...

The questions around how we continue to explore, expand, learn and teach the art of a balanced, hands-off approach are, I feel, vitally important. How do we ensure that student midwives can gain enough experience of vaginal examination to feel confident about what they are feeling when they do need to perform this when we, their mentors, are also trying hard not to subject women to more vaginal examinations than are truly necessary? How do we enable students and newly-qualified midwives to feel confident with the manual manoeuvres which are rarely used in hands-off practice, yet which might one day be the very thing they need in a particular situation? How can we teach and share less invasive forms of labour assessment such as auditory and visual observation using physiological signs like the purple line?

Perhaps most importantly of all, how can we continue to explore and encapsulate the cognitive tools and criteria which experienced midwives are using to decide when an intervention is essential and life-saving, and when it is unnecessary interference, such that we can further our knowledge and share this with those who follow us? All of these questions are rather interesting ones, and, in many ways, it is rather exciting that we have reached a point where we need to
explore them, because the fact that we need to ask them is indicative of the increasing autonomy experienced by women and midwives. Rather than seeking to balance the humors, as our ancient colleagues did, the challenge for modern midwives is not only to perfect the art of balance in our own practice, but also to find ways of expanding and sharing this art with those who follow. Kudos to Maggie for creating a space in which women and midwives can safely share their thoughts, knowledge and wisdom, raise questions and then work together to explore the possibilities.

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