CHILDBIRTH DEFINITIONS AND CHILDBIRTH EXPERIENCE

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This article is dedicated to changes that have occurred in Czech obstetrics over the past decade. The debate about Czech obstetrics has been opened in the media particularly by women's organizations in the second half of 1990s. These organizations opened the debate especially on the issue of mother's experience of childbirth and put it opposite to medical experience. Both these approaches – medical and mother's experience – are today considered relevant and media give space to debates between parents, medical authorities and women's organizations about the image of Czech obstetrics. As a result, these debates have enjoyed more media success than other efforts of women's organizations, which have not received much press. Mothers' experience of childbirth became more visible because of the disruption of the institutional, psychological, and media silence on one hand. On the other hand, the debate also entails the efforts of midwives who are striving to achieve their former professional autonomy.

Although this article is dedicated especially to topical, social, and medical changes in Czech obstetrics, the fact that permanent medical as well as social changes in childbirth practice depend on medical knowledge, fashion, ethics, and other social circumstances will pervade the text.

Sources of data

With respect to my theoretical background, I will draw on social-constructivist approaches applied in the field of medial sociology, and especially the part of medical sociology labeled by Strauss and Sokolowska as sociology "about," not "for" medicine. According to them, sociology "about medicine" concentrates on changes in the medical practice while sociology "for medicine" concentrates on the influence of life events on the incidence and development of illness (Vodakova 1994: 86).

Empirically, I will build upon 25 non-structured qualitative interviews with obstetricians, midwives, and leaders of women's organizations who deal with the issue of Czech obstetrics. In the case of obstetricians and midwives I focused also on the reported changes in the obstetrics practice in their own workplace. I also examined narratives of women concerning their experience of childbirth published on Czech web site for parents (www.rodina.cz); an overview of thematically related Czech media articles since 1960s; medical as well as sociological statistics based on questionnaires examining the obstetrics practice in individual maternity wards in the Czech Republic ("Porodnice 2000"); and data from quantitative representative attitudinal survey of mothers with children up to 1 year of age ("Matky 2000"), of first-time pregnant women ("Tehotne zeny 2000"), and of obstetricians ("Porodnici 2000") concerning the current state of Czech obstetrics conducted in 2000 by Open Society Fund Foundation and STEM.

Childbirth as a socially dependent variable as well as a social factor

A birth is a significant life and family event that influences intra-personal, interpersonal, and socially significant facts. Childbirth and especially the first birth in the life of women and men influences their social and economic status, roles, relations to each other as well as to other relatives and non-relatives, carrier plans, division of labor between family members, and other important life affairs.

The significance of childbirth, its course and results are also to a certain extent influenced by the sociocultural context (Jordan 1997; Chapman 1986; Georges 1997; Kitzinger 1997; VanGennep 1997]). Depending on actual differences in time and space, different people have been considered responsible for conducting a childbirth, different spaces have been considered as the right ones for a childbirth, different preferences in conducting a childbirth have occurred as well as changes in other social aspects that influence a conduct of a childbirth, such as position of a child in a society or the system of heredity.

This was very well expressed, for example, in Leavitt's article (1987), which

analyzed a debate among obstetricians of complicated birth cases in medical journals at the beginning of 1880s. According to her study, at that time in western Christian space, priests and fathers of infants were still present in the same room as the laboring women during complicated birth and made decisions about what interventions could be provided by the obstetrician-surgeon. Besides the impact of Christian morality (which saw an infant as sinless and opposite to sinful women in situations where decisions had to be made concerning the health of laboring women and the health of infant) on the conduct of complicated childbirth, she pointed out also a tendency to make decisions to protect the firstborn with greater effort than other infants.

But there have been also significant differences in conducting birth within the western Christian space. In England, the life of an infant was valued less than on the Continent. This resulted in practicing craniotomy (destruction of fetus due to the perforation of the fetus' head) more often than in Continental obstetrics, while symphysiotomy (which could led to permanent harm of the mother) or Caesarian section (which, in the middle of 19th century, still resulted in the mother's death in half of the cases) were performed in England less than on the Continent (Leavitt 1987; Zeman and Dolezal 2000).

Although one might be tempted to say that these shifts in focus either on a mother or an infant seem to be in the distant past in the European cultural space, the reality does not confirm this proposition. The question of the priority of protecting either the infant or the mother has once again gained prominence in the context of increasing the number of in-vitro surgeries, and especially the question of to what extent the morbidity of a mother is acceptable in order to protect the life and health of a fetus.

Moreover, according to the interviews with Czech obstetricians and midwives, they connect a shift in focus from the infant to the mother to such current changes in Czech obstetrics in 1990s as the opening media discussion about psycho-socio-physiological childbirth experiences of mothers themselves, the pluralization of healthcare practices, and the reduction of routine use of some techniques such as cardiotocographs.[1] They also spoke of the trend toward de-medicalization of childbirth that has actually been implemented or is being implemented vigorously in some Czech maternity wards, and of the strategic masking of other wards' strong reliance on technology in order to improve the psychological comfort of mothers while at the same time preserving the medicalized approach to childbirth.

Scientific knowledge as a social construction

The fact of actual de-medicalization or masking of medicalized childbirth practices as well as the appearance of the maternity wards must be understood within the period's wider social context. While the previous trend of childbirth medicalization fell within the framework of the success of bio-medicine and the natural sciences prevalent at the beginning of the 20th century, which celebrated its greatest victories especially after the Second World War, the concept of de-medicalization of the childbirth, which some experts and a part of general public are trying to implement, was developed as a reaction to this medicalization and with a wave of criticism of acute bio-medicine. This occurred especially in countries where universal preventative pregnancy checks have been already introduced to women and technical devices became a standard part of maternity wards and labor rooms. These conditions contributed, on the one hand, to the formulation of a concept of a risky pregnancy and childbirth and acute biomedicine became a certain guarantee of safety of pathological pregnancies and childbirth. On the other hand, though, these technological developments also contributed to the definition of a great majority of pregnancies and childbirths as low risk.

This occurred at a time of shaping societies, which Ulrich Beck [1992] calls risky. In these societies, based on their recognition of some side effects of technologies as products of modern Western positive science, the optimistic trust in modern society as "society of securities" came under attack, along with the criticism of modernist understanding of science.

The idea of cumulative science has been problematized and in the 1960s was replaced by Kuhn (1997) with an understanding of science occurring in paradigmatic shifts. Emphasis was newly placed on the fact that decisions of scientists who produce and later confirm the influential definitions of reality are themselves influenced by social, political, and economic contexts. From these positions, science as a neutral institution "revealing" rather "co-creating" truth has been problematized.

To be concrete, in the field of the sociology of medicine, it became possible to view

processes whereby expert professional commissions define the limits of truth – and thus, also the border between orthodox and alternative medicine – with respect to the exercise of power. Consequently, they also define which practices will be implemented and which not.

To be even more concrete, in obstetrics, this involves, for example, the issue of water-birth. The question is: Can professionals "allow it" for mothers? Will it not be too dangerous for mothers or infants? Will it be useful? In the course of the second half of 1980s, this also involved the issue of rooming-in (the possibility for mothers and infants to stay together in one room after the birth, not divided into separate maternity and infant wards).

Nowadays, rooming-in is promoted as a mainstream in the Czech Republic.[2] The previous fear of infection transferred from the mother to the infant was replaced by a fear of psychological and physiological damage caused by the separation of the mother and the infant after the birth. (This previous fear of infection emerged especially in the 19th century, when due to an imperfect knowledge of sterilization, seption, and antiseption, thousands of women and infants were killed in hospitals where dissection was performed).

A similar course of criticism of a certain practice may be documented on the issue of breastfeeding. While artificial nourishment prior to the 1970s was seen as a way to rescue mothers from their biological obligations, it was labeled as insufficient for the baby in comparison to breastfeeding in the 1970s.

In addition to these changes, the presence of a close person (usually the father of the child) during labor was newly promoted during 1990s. Because of the previous prevailing fear of infection that could be transferred from the father to mother or infant, fathers could not even visit their partners in the puerperium wards after the birth. After the formulation of the psychological risks of separation of mothers from people close to them, which was said to support mothers' weak position and uncertainty and cold behavior of a hospital personal towards them, fathers were admitted to the puerperium wards and after that to puerperium rooms during visiting hours. Nowadays, they are admitted not only to some puerperium single rooms for whole 24 hours, but even to labor rooms (according to the survey "Porodnice 2000").

Similarly, the risks of labor during which a woman stays in positions other than the prone one are being slowly replaced with the formulation of the risks of the prone labor position. In addition, episiotomies were performed increasingly from the beginning of 20th century up to 1980s in the Czech Republic, when it was routinely performed during almost every birth, even spontaneous and low risk childbirth. However, nowadays it is becoming restricted (according to the surveys "Porodnice 2000" and "Porodnici 2000") to only 15-20% of all childbirth in some Czech maternity hospitals. It started to be considered unnecessary in most cases, or, even more drastically, as a mutilation of the female body if performed routinely. Furthermore, there have been changes with respect to the once popular cardiotocographs, which later came under strong criticism in the cases of its use during low risk childbirth.

It seems that this development of the introduction of a practice, its spreading to most childbirth cases, and the subsequent criticism of its too frequent use is partly caused by a tendency to routinize medical activities in a hospital and partly by permanent changes in the medical fashion (both on the professional and lay side). Routinization, which is so common in hospitals, certainly simplifies the provision of healthcare for the medical staff. In addition, it protects medical staff against accusations of failures. According to interviews with doctors, once a certain practice to reduce a kind of risk of complicated childbirth is proven helpful, it starts to be practiced routinely in most childbirths. This is the case because it is easier to accuse somebody of forgetting to do something than of doing unnecessary and therefore harmful acts in the case of childbirth. Also, it has to be added, that the division between complicated and uncomplicated childbirth is also to some extent a matter of social construction, as is the definition of childbirth and its risks.

According to Beck [1992], contemporary societies have become full of uncertainties and risks. But the risks are not primarily a reaction to impulses coming from the external world but are constructed on the consequences of technological interference. They are primarily constructed on the borderline between expert specializations. They are never pure facts but have their own theoretical and normative components. They are defined on a causal basis using a scientific rhetoric, since the industrial society is based on specialization and trust in scientific rationality, argumentation, and logic. At the same time,

however, they are fed by exemplary examples, which take the form of tragic narratives. In view of the fact that they are mostly defined in statistical figures (for example, how many times the likelihood of an instrumental childbirth increases during childbirth in the prone position or when applying epidural anesthesia), the risks may be made more dramatic, amplified, or downplayed according to the intention of the speaker.

From this point of view, we may view various social definitions of childbirth that clash in a rhetorical battle in professional and popular science fields while finding practical use in various maternity wards. These definitions of childbirth either construct childbirth as a risky bodily matter which must be technically and medically supported, or as a "natural" matter, the risks of which consist rather in iatrogenic side effects of medical interference with the natural bodily course of childbirth.

Adherents to this second definition of childbirth and the de-medicalization of medical care teach women to be active actors of their childbirth, to react to the demands of their own bodies with learnt physiological techniques, and not to be consumers of medical care.

The negative side effects of medical and technical interference with the physiological process of childbirth are defined mostly as "a spiral" of medical interference, one such incident causing another – for example, using cardiotocographs is connected to the prone position of laboring women.[3] The prone position is believed to increase the number of instrumentally completed childbirths. During instrumentally completed childbirths (except the Caesarian section), episiotomy must be performed (Harvey 1992; Odent 1995; Podalová, Hohlová, Malý 1999; Wagner 2000).

As it is obvious from the lines above, although the critique of the modern understanding and shaping of the external world has also brought the construction of its risks, these risks are defined using the language of the criticized modern science because then, and only then, could it be accepted both by the expert and the general public as sufficiently relevant. There have to emerge other experts who would refuse the old conception of childbirth practice, formulate it as risky, and offer a new conception that would be presented as solving the existing problems. Because of that, according to Beck (1992), this critique – rather than being a refusal of modern science and its techniques – is their transcendence, an expression of the contemplation of modernization and modern science from its own positions.

Midwives struggle for professional autonomy

It is clear that the tendency toward de-medicalization of childbirth was hailed by Czech midwives, who by law have a restricted ability to apply medication, and their more independent work is narrowed down only to non-complicated spontaneous childbirths where they use primarily the knowledge of physiology and psychology. A portion of them has related the support of this trend to the battle for recognition of their professional autonomy, which they lost at the beginning of the 1960s. At that time, the separate position of a midwife was abolished and in connection with this, we saw a terminological and expert transformation of midwives to "women's nurses," who thus lost their autonomous position in cases of non-complicated spontaneous childbirth and became doctor's assistants, as interviews with midwives and doctors revealed.

The struggle of Czech midwives will not be easy, although there is the example of some western European countries, where the best bio-medical results of natal care and the lowest values of maternal and perinatal mortality are recorded and where midwives conduct a majority of spontaneous childbirths at the same time, whether at clinics – in case of Sweden – or at home – in case of Netherlands. In addition, Czech midwives define the results of the demanded achievement of their professional autonomy as the achievement of greater flexibility and plurality of childbirth care, the mitigation of the hospital organizational hierarchy pyramid, the transfer of collective responsibility of the team involving doctor and nurse to an individual, and a decrease in financial cost of the childbirth care. Their struggle will not be easy also because some obstetricians see their efforts as a breach of the medical monopoly, that is, the established hierarchy of positions. Moreover, Czech midwives have become associated with two different professional organizations, but only one of them supports publicly the idea of professional autonomy in conducting childbirth. Thus these midwives supporting the idea of professional autonomy do not know the degree to which their struggle is supported by other Czech midwives, who are members of the other professional organization or who are not members of any midwife professional organization at all. Definitely not all Czech midwives support the idea of the growth of their professional autonomy. On the one hand, it would

probably bring the growth of public recognition of midwifery and the growth of the financial rewards of their work. But on the other hand, the autonomy would also bring the growth of direct responsibility of each midwife for the whole process of conducting of a childbirth, for which they are often not lead in hospitals.

Towards Civic Society

Despite what has been written above in this article, changes in Czech obstetrics did not occur during 1990s only under the pressure of differences in opinion among professionals, but also under the pressure of general public. In view of the fact that childbirth is an important event and an emotional experience in the life of a woman and the entire family, it has always been the subject of private narratives and the transfer of experience among women. It has, however, become part of the public media debate only after 1989 to greater extent. Largely, this is an outcome of the activities of women's NGOs dedicated to the issue of childbirth, which could not have been established before 1989 due to political-legislative reasons.

In the context of obstetrics, the women's NGOs that have to be mentioned are the women's movement "Movement for Active Childbirth" and the association "Aperio," both of which were established toward the end of the 1990s as split-offs from one of the programs of the "Open Society Fund Foundation."

In cooperation with other women's organizations, such as "Gender Studies Foundation" and the publishing house "One Woman Press," and professional organizations such as "Czech Association of Midwives," their members managed to bring the issue to the attention of the media and to organize an international conference and several discussions and seminars with representatives of the professional and general public in the field of obstetrics (thanks to the financial support received from the Open Society Fund Foundation whose goal is to support the development of civic society). Furthermore, translations of several foreign books on the preparation of women for childbirth and a selection of obstetrics practice were published. The most important publication, though, was the "Guide on Czech Maternity Wards." The Guide is to serve mothers when selecting the hospital in which to give birth and offers an overview of services, obstetrics instruments, and preferred practices of birth conduct in each Czech maternity ward as described by the management of these maternity wards. It also includes commentaries of mothers who gave birth in each particular maternity ward over the course of the last year.

It must be noted that immediately after 1989 the attention of the media was turned to other aspects of the sociopolitical and economic transformation, which were considered – and publicly even explicitly defined as – socially more pressing than the issue of obstetrics or other issues concerning the female population, such as the position of women in society and on the labor market, or the degree of women's participation in decision-making etc. On the other hand, it must be stressed that the media coverage of civic initiatives concerning motherhood and pregnancy were one of the most successful presentations of the activities of women's NGOs in the second half of the 1990s. The press given to the issue of childbirth was friendly to their activities, while media coverage was not very friendly to women's civic initiatives in general, especially during the first half of 1990s. Success of the NGOs dealing with childbirth and motherhood came despite the fact that they were often established later than other NGOs. The first women's NGOs emerged in the year 1990 (Cermáková, Hašková, Krízková, Linková, Maríková 2000: 34) but NGOs dedicated to obstetrics were not established until the end of 1990s.

This relative success in the media of women's civic associations dealing with motherhood and pregnancy may be attributed to the continued gender contract, which defines certain spheres of human life as male and others as female. While issues such as women's participation in politics, gender discrimination on the labor market, etc. have come to be associated with feminism, which at the beginning of 1990s was denigrated by repeatedly describing feminism only in a militant or caricatured way (of unacceptable fight between men and women) and nowadays it is only slowly increasing the number of articles with description of feminism based at least on some real knowledge about it, issues of motherhood, pregnancy, and birth were not labeled in this way.

Although demands concerning the reduction of paternalistic attitudes of medical personnel toward patients have been articulated in Western Europe since the 1960s, in the context of formation self-help, self-care, and patient movements, entrance of clinical psychologist to hospitals and growing of costs for medical care, in the Czech Republic the first signals of these

changes in healthcare came approximately twenty years later. As was already suggested, only today are they supported publicly. This is possible only thanks to the change in the political regime. To be concrete, in obstetrics, we have seen a move away from the enforcement of changes strictly "from the top" and a crucial turn in the perception of the mother with respect to her ability to participate in decisions concerning the manner in which she will give birth to her children.

But it has to be stated that according to the survey "Tehotne zeny 2000" and "Matky 2000," it is in particular women with secondary and tertiary education, women who take care to gain information about childbirth through reading, and women with a previous experience of childbirth who actually participate most actively in decision making about the way they give birth to their child.[4]

Also, the degree of consent with women's participation in the implementation of changes in obstetrics varies greatly among professionals. It reflects the long-term absence of civic participation in this sphere. This was already pointed out by Heitlinger (1987), who in the 1980s conducted a comparative survey of obstetrics and motherhood in the then Czechoslovak Socialist Republic and Great Britain – as representatives of the Western and Eastern Blocs. She postulated that the influence of civic society (the effects of the activities of interest associations and other civic initiatives) on the manner in which childbirth care is provided is one of the typical features of Western European healthcare systems, in opposition to the absence of such initiatives within the socialist organization of healthcare. According to her analysis of documents, in Western Europe – unlike the former Czechoslovak Socialist Republic – there were public debates about the continuous reform concerning the provision of childbirth care not only among the professionals but also the general public dealing with obstetrics.

Attitudes toward Male and Female obstetricians

When talking about the stronger participation of women in the implementation of changes in the provision of childbirth care, we mean primarily women among the general public dealing with obstetrics. On the other hand, the firmly anchored gendered structure of obstetrics must be emphasized. In the hierarchy of doctor-midwife-woman in labor, the greatest legal responsibility for the course of the childbirth in this surgery field is still born (according to the survey "Porodnice 2000") by men-doctors in two-thirds of cases.

Due to the gender stereotypes that are still firmly embedded in the minds of Czech men and women, the competencies of female professionals are considered lesser, even within the framework of this specifically women's issue - birth. This belittling comes not only from male colleagues who predominate in this field but also from the public. But it has to be stated that these attitudes towards male and female doctors that still prevail, especially in the field of obstetrics, which is considered to be a surgery field, do not apply to gynecology practitioners, where the proportion of female doctors is not as low as in obstetrics. A certain portion of women do feel more comfortable attending a female, not a male gynecologist.

Female obstetricians are considered to be less equipped both in nature and abilities required for the management of complicated or operative childbirth cases (in addition to the physical capabilities, this concerns the ability to make fast decisions and display "strong nerves"), and also in characteristics that are attributed to obstetricians conducting de-medicalized spontaneous childbirth. In addition to the openness to new non-conservative procedures, male doctors are also attributed greater professional self-confidence, often related to practicing de-medicalized childbirth.

These characteristics attributed to men or women function as gender stereotypes. Thus, they are considered to be unchanging, a part of the natural makeup of men and women. Consequently, the social and organizational conditioning of these characteristics is not questioned and they are not subject to corrections in the face of one's own life experience.

Summary and conclusion

By way of summarizing and concluding, it should be underscored that definitions of childbirth and obstetric practice change over time and space based on social, political, economic, and cultural contexts, and especially based on the medical paradigm, fashion and, ethics. The description and explication of the changes in obstetrics in contemporary Czech society provided herein suggests that especially over the last decade we have seen de-medicalization and differentiation of childbirth care under the strong influence of social transformation. It is primarily women in labor who profit from these changes because there is

nothing to suggest that the risks of childbirth, as defined by biomedicine, have increased with these changes while psychological support seems to be improving.

This conclusion, however, may be counteracted by the fact that (according to the survey "Porodnice 2000") thus far not even one fourth of Czech mothers whose childbirth was spontaneous had the possibility in the year 2000 to select their childbirth position, although the choice of position during childbirth correlated strongly with the general satisfaction of the mother during childbirth. These facts weaken the idea of a general large-scale shift in the Czech obstetrics practice towards a greater participation of women in labor in the determination of the manner in which they will give birth in cases that are uncomplicated and spontaneous.

Nevertheless, we have seen significant and real changes in obstetrics on the local level and the debate has opened up on the national level. It may be summarized then that the current state of obstetrics in the Czech Republic is starting to look different from the one described by Heitlinger (1987) in the 1980s. Clearly, we have seen: 1) opening of the maternity wards to the public; 2) opening up of a dialogue between professionals and the general public on the form of Czech obstetrics in the Czech media and on concrete childbirth in everyday medical practice; 3) a gradual shift from the paternalistic attitude of healthcare personnel toward women in labor to a greater freedom of women in labor to participate in determining the course of their labor; and 4) inclusion of the issue of quality of childbirth care in the agenda of issues addressed within the network of newly created women's NGOs and professional organizations.

According to interviews with obstetricians and midwives, the proponents of the actively conducted medical childbirth predominant in Czech society perceive the current changes in obstetrics primarily as the commercialization of medical care. Their opponents pushing for de-medicalization of childbirth define this change as a consequence of the psychologization of childbirth, and position themselves in the role of those who take into account the psychological experience of women during childbirth, something bio-medicine disregards. Both sides, however, talk about individuation and pluralization of healthcare, which they understand as one of the main features of the current trend in healthcare in general. No matter what form the already mentioned individuation of care at individual workplaces takes, Czech healthcare professionals define their current practice against the constructed "former" type of care which is characterized as routine and standardized by both sides.

Although in interviews doctors have reflected upon the changes in the direction of individualization and de-medicalization since the beginning of the 1980s, when rooming-in was introduced in Czech maternity wards for the first time, it is true that on the general level they associate these changes with the 1990s. Implicitly but also explicitly they make a connection with the general societal change, which also takes the form of greater individuation and the possibility of free personal choice.

These changes reflected in the differentiation of the manner in which childbirth may be conducted may be viewed within the wider context of demographic, political, economic, and social changes supporting the creation and free activities of civic associations and professional groups just as competition between maternity wards. This competition occurs under the pressure of economic liberalization and a dramatic fall in the birthrate[5], because in the 1990s it became officially possible to select one's own doctor, which has indirectly lead to competition between maternity wards fighting for financial survival in the context of a dramatic fall in childbirth.

The perception of this post-1989 change, however, must again be counteracted by the fact that before November 1989, there was certain differentiation in childbirth care hidden behind the facade of uniformity. Nevertheless, it may be claimed that after 1989 the processes of change have become visible and their dynamic, nature, and ways in which they are legitimized have changed.

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[1] According to interviews with obstetricians, cardiotocographs are believed to increase indirectly the number of Caesarean sections while its outputs are believed to be interpreted more frequently as a bad condition of a fetus than it really is.

[2] In some other post-communist countries the situation is not the same in this case; rooming-in is not mainstream but rather the exception there.

[3] Older cardiotocographs which were connected to the prone position of laboring woman are being nowadays replaced by much more expensive new kinds of cardiotocographs that are smaller in size and because of that can also be used in different body positions.

[4] Variable "degree of interest in gaining information through reading" and variable "degree of level of education of a mother" correlate together on the one hand but the variable "degree of interest in gaining information through reading" cannot be filtered out by the variable "degree of level of education of a mother" while explaining participation of woman in decision concerning the conditions of her childbirth.

[5] While at the beginning of 1980s were 15 live births per 1000 inhabitants, in the second half of 1990s it did not exceed 9 live births per 1000 inhabitants.