In an age where childbirth has become dominated by pharmaceutical advances, technological interventions and the 'medical model', it is more important than ever to question what it is that we do when attending birthing women, and how appropriate our actions are. Those of us who seek to assist childbirth using the age-old art and craft of midwifery need to be willing to open our minds to discussion of what is truly useful to women and what may be unhelpful, especially when used routinely.

As the number of 'true thinkers' in midwifery increases, so do the examples of areas of midwifery practice which have been re-conceptualised by those who have asked the right questions - and sometimes also suggested answers. While birth has been dominated for so many centuries by patriarchal attitudes, the process of critical questioning (lateral thinking, analysis, reflection) is enabling us to reconsider the foundations of the knowledge we possess about birth. We can then, where appropriate, rebuild this knowledge in response to what we have learned and in ways which are more in tune with the needs of women.

At this point in time, I would suggest that we don't have nearly enough "midwifery knowledge", especially about the interventions and routines which are being imposed on women. Perhaps critical questioning can enable us to look openly at other interventions in order to explore when and how technology may be appropriate - and when the opposite is true. Somehow we need to explore our own midwifery knowledge base in different areas within a framework which is truly women-centred.

Yet it is important not fall into the trap of assuming that everything 'medical' is an intervention, and everything 'midwifery' is not. As Tricia Anderson (2002) points out, we also need to deconstruct the things that midwives do – and how these actions and words are also interventions have an impact on women. She argues that everything we do should be considered an intervention; asking a woman to change her position, 'guarding' or massaging the perineum, drying and warming a newborn baby. This is not to say that these things are necessarily inappropriate, but that we need to begin – and continue – a dialogue about "what midwives do".

Categorising Interventions

Recently, I have begun to attempt to categorise some of the kinds of interventions which women might be offered (Wickham 2002). Table 1 shows the four categories I initially came up with; screening tests, clinical interventions, prophylaxis and selected interventions. The most important thing this highlights for me is that it shows the need to understand why we are setting out to do something, and what questions we need to ask ourselves – and the woman – in order to determine whether what is being suggested is really beneficial. After carrying out this exercise, I realised just how many of the things we routinely do, especially during prenatal visits, are screening tests. Given that the point of a screening test is to detect a deviation from the norm in order to be able to act on that information, how much can we really do to help women who are not 'within normal limits'?

It should also be noted that some interventions (examples are marked with an asterisk) might fall into more than one category. For instance, perineal support at birth may be practised as routine prophylaxis to prevent perineal tears, or as an individual clinical intervention when indicated by the experience of an individual woman and her midwife. This list is not inclusive of all possibilities, and it forms only one way of considering these issues. Indeed, Tricia's work highlights a number of other categories of midwifery interventions, including:

- Reassurance (e.g. verbal, via touch)
- Manipulation of the external environment (e.g. ensuring privacy, keeping the room warm, protecting woman and baby from intrusions)
- Psychological (e.g. asking the woman to 'let go' of her placenta)

Table 1: Categorising Pregnancy and Birth Interventions

TYPE OF INTERVENTION	DESCRIPTION	PRACTICE EXAMPLES	TYPES OF RISK AND BENEFIT TO CONSIDER	SITUATION IN 'MAINSTREAM' PRACTICE
SCREENING 1. OF WOMAN 2. OF BABY (n.b. antenatal screening carried out on women, but often actually screens baby.	Used to detect potential deviations from the norm.	Ultrasound, TPR, BP, VE, Hb, BPP, Kleihauer, EFM, FBS, measuring fundal height, antenatal check, postnatal check, Guthrie test.	How accurate is the test? Risks of false positive and false negative. Impact on the woman's psyche. Who is defining 'normal limits'? Will result change 'management'?	Many have been challenged but most are still a feature of 'normal practice' in organised maternity care.
CLINICAL INTERVENTION 1. ROUTINE 2. INDIVIDUAL	Used to bring pregnancy / labour / situation back in line with 'normal limits' (eg time, Hb levels).	Induction, ARM, cytotec, augmentation, blood transfusion, rhogam* cord care*, perineal support at birth*, counselling, forceps, vacuum extraction, 'crash' or emergency cesarean section.	Physical and other risks. Side effects. Cascade effect of intervention.	Becoming more accepted as not being a good idea routinely – seen as more appropriate as responses to individual needs. 'Normal' still needs defining.
PROPHYLAXIS 1. ROUTINE 2. INDIVIDUAL	Used to prevent potential problems from occurring. Does not itself give information on the likelihood of a problem.	Vitamin K, rhogam*, cord care*, perineal support at birth*, withholding foods and fluids in labour.	Efficacy (does it actually work?) Do the risks outweigh the benefits on a routine basis? What are the implications?	Many of these would become individualised rather than routine if the evidence for their appropriateness were followed.
SELECTED INTERVENTION 1. MATERNAL CHOICE 2. ON MEDICAL ADVICE	May be unrelated to the general situation or impacting 'progress', but still used as an intervention in a proportion of women.	Pharmacological pain relief (epidural, pethidine, entonox) Elective cesarean section where this is performed by maternal request.	Do the risks outweigh the potential benefits to the individual woman? Hugely emotive and raises lots of ethical questions regarding choice.	At times, these examples may become clinical interventions – according to individual needs and situations. Depends on the 'indication'.

Thinking Interventions Through

So how can we begin to think through the interventions we use, and determine whether they are truly useful for women? Using an example from the table above, we might ask ourselves if it is really useful to measure fundal height during pregnancy. The basic aim of measuring fundal height is to determine whether a baby is growing 'within normal limits'. Table 1 classifies it as a 'screening test'.

The idea that measuring fundal height (or, indeed, performing any screening test) is a beneficial intervention to perform on a routine basis assumes that:

- It is possible to measure fundal height accurately. (Is this the case, or might there be differences between the people and / or instruments used?)
- There is agreement over what 'normal limits' are. (Are current guidelines based on physiological principles?)
- It is possible to 'act upon' findings which suggest that the baby is not growing within 'normal limits'. (Is this really the case? Is there a clinical intervention which can enable the baby to grow faster – or slower – and actually affect the outcome in this situation?)

The other questions that might be asked in relation to this screening test include:

- What is the rate of false positive and false negative results? (i.e. how many babies deemed 'small for gestational age' turn out to be bouncing eight-pounders, and how often are 'small for gestational age' babies not picked up during prenatal checks?
- What is the potential impact on the woman's psyche of being told her baby is smaller or larger than average? (Especially where there is no effective 'treatment' for an adverse finding)
- What is the evidence relating to 'small for gestational age' babies generally?
- Might nutritional advice impact on the situation? Could a woman's diet affect the rate of baby's growth? How does this relate to the idea of using fundal height as a routine screening test? What about the idea of offering basic nutritional advice to all women as a preventative measure?

When we are considering the relative accuracy of using our hands and experience or using a tape measure, we might also consider the other qualitative factors which impact the situation (e.g. the height and weight of the woman, the position of the baby, any previous experience of the woman – does she carry her babies in a particular way? Does she never look very pregnant but give birth to 9 pound babies?) Some midwives argue that a tape measure is no substitute for being able to take these factors into account.

Given these questions, we may feel it is no longer appropriate to use the measurement of fundal height as a routine screening test, but rather to gain individual information about the pregnancy and as a tool for reassurance rather than worry. Would it be better to reflect on the appropriateness of this for individual women rather than as something we do at every prenatal visit?

I realise that I have only raised the questions here, and not provided all of the answers! This is, in part, because I feel we all have to make decisions about our own practice, in the context of the women we work with and the things that are individually useful. This is only one example of the type of question which can be applied to practice in order to challenge the routine and consider the 'bigger picture' which may affect a woman's situation. As more midwives become interested in this kind of critical thinking, it is almost inevitable that we shall see a further increase in the volume of midwifery knowledge. Would anyone care to question the proposition that this would be a good thing for woman, babies and midwifery?!

Anderson, T (2002) Peeling back the layers: a new look at midwifery interventions. MIDIRS Midwifery Digest 12(2): 207-210.

Wickham, S (2002) What's Right For Me? AIMS, London.