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Subjective Evaluation of Perinatal Care Regulation

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ABSTRACT: In France the policy of regionalization and organization of perinatal care is governed by a Decree issued in 1998, the objective of which is to improve prevention of premature births and perinatal risks. Within this context, forty-nine health professionals were interviewed by means of a qualitative questionnaire designed to evaluate implementation of the Decree. The present report is primarily an analysis of the mechanisms and psychosocial issues of over-medicalization of birth. This over-medicalization stems from the interacting effects of competence grading, linked to the grading of health facilities, and the process of pathologization / surgicalization / judiciarization of birth.

KEYWORDS: healthcare, perinatal care, hospitalization, surgical, birth, regulation, competencies, participation, control, network

INTRODUCTION

Context and Interest of Subjective Evaluation of the Network by Professionals Specialized in Perinatal Care

Over the last twenty years or so, most industrial countries have developed guidelines on regionalization of perinatal care (Campbell, 1991). One of the important goals of perinatal regionalization is to improve morbidity and mortality outcomes of preterm and low-birth-weight new-borns by transporting pregnant women to maternity

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units that have a medical or neonatal environment suited to the risk incurred by mothers or babies.

France's performance lags behind that of other European countries when it comes to perinatal care (Blondel et al., 2001; Kollée et al., 1999), despite the arsenal of successive decisions on childbirth and on the development of perinatal techniques and antenatal diagnosis, such as the 1994 Perinatal Plan, the 1996 Edicts (*Ordonnances*) on health networks and the 9 October 1998 Decree on perinatal security. These measures instituted a policy of regionalization of perinatal care, which completely altered the previous system. Each maternity unit has been assigned a level of care (I, II, or III), and pregnant women are classified according to their 'risk level'. On that basis, pregnant women are referred to maternity wards with the appropriate medical environment to provide adequate care for them and their infants. The policy therefore also entailed the restructuring of maternity wards in relation to the level of maternal and paediatric care available in the institution.

One of the main features of the policy was the referral of women at risk of giving birth prematurely, to maternity wards classified as Level III (those with a neonatal reanimation service on site) or Level II (those with neonatal intensive care but no reanimation). 'Low-risk' women were to be referred to Level I maternity wards (those without a neonatal care service).

The international literature has shown that women's transfer to hospital (level III) before delivery increases the likelihood of highly premature birth (Hein et al., 1986; MacCormick et al., 1985; Peddle, 1983; Schlossman et al., 1997; Truffert et al., 1998). Moreover, several surveys in English-speaking countries have shown that women tend willingly to agree to 'light' perinatal care (Biro et al., 2003; Harvey et al., 2002; Mac Vicar et al., 1993; Turnbull et al., 1996). Yet the effectiveness of the policy of regionalization of care, as a whole, is still under discussion and has provided no conclusive evidence as to its validity (Truffert, 1996; Zeitlin et al., 1999).

METHOD

How the Professionals of Perinatal Care Perceive the Decree: Pioneering Research in the Rhône Département (France)

Even though France has experience in the implementation of regionalization policies (Blondel & Grandjean, 1998; Dreyfus et al., 1998), few publications report the results in terms of efficacy on

mothers' and infants' health (Cornet et al., 1998), and even less so in terms of perception of this health policy by users or health professionals (Naiditch & Weill, 1996).

We therefore considered it essential to examine how the health professionals in the sector under consideration perceive the objectives and implications of this network and, more precisely, the subjective effects it produces, and how they analyse the changes it triggers in the reorganization of their work, in their relations with one another and with the public concerned (parturient women, fathers, family), and especially in childbirth-related care.

The French perinatal care network under consideration was the Rhône network (around the city of Lyons). It includes 3,100 professionals, working in 24 maternity units, where 26,500 pregnancies/year are treated. From this population, 49 persons were contacted by mail and telephone, and all agreed to participate to the study. They were interviewed using in depth semi-structured interviews after stratification of the following professional characteristics:

- medical speciality (anesthesists, gynecologists, neonatologists, general practitioners, obstetricians, midwives, MCWC professionals;
- legal status of the institution (private hospital, public hospital, private practice);
- care level of the maternity unit (I, II, III): the study was conducted in six institutions: 2 Level-III public-sector institutions, 2 Level-II and Level-I public- and private-sector institutions, 2 private practitioners' surgeries.

An anonymous and exhaustive transcription was made of the tape recordings. (Durif-Bruckert et al., 2001)

In this article we consider the way in which the respondents discussed the iatrogenic dimension of the Decree, relative to the risks of hyper-medicalization of childbirth that it tends to generate and increase. We then analyse this process around the respondents' two lines of argumentation: the ranking of competencies, based on those of medical institutions, and the schema of intensified pathologization and surgicalization of birth and, inevitably, its 'judiciarization'. Based on these two axes, we discuss the psychosocial implications structuring and reinforcing the phenomenon of 'expertization' and the process of over-medicalization.

RESULTS

The Process of Over-Medicalization

Cross-cutting analysis of the interview content reveals two main lines of argumentation: the interest of the network concept, and the perversion of its application. Perception of the network and its representations (Jodelet, 1989; Moscovici, 1976) is therefore structured at the intersection of two articulated axes. The first corresponds to arguments in favour of the main characteristics of a care network based on cooperative relations around a common 'mission': medical security of childbirth. No doctor disputed this. On the second axis, which is predominant, the Decree seems to officialize the following objectives (that tend to be increasing in importance in the hospital care system): an approach to childbirth as a highly risky event, and an attempt to keep it under control. In this perspective, the respondents focused on the worrying aspects of striving to control all risks, and on the pathological reactions that it triggers.

Ranking competencies and damage to practices

Note: Abbreviations used in brackets after citations to identify the respondent: O = obstetrician; MW = midwife; P = paediatrician; A = anaesthetist; I, II or III = institution care level in which the respondent works.

A large majority of the health professionals interviewed say they are aware of the risks of *'competition between institutions'* (O,I). These risks are generated by the distinction of levels: the 'low levels' which are likely to be eliminated in the long run, as opposed to the centres of 'high-tech medicine' (Level III) which 'produce specialists of pathology', a costly status built on the exclusion of those who are not part of it.

Health care professionals in Level I (and certain Level II) institutions are convinced that the network functioning has reduced their capacity to practise. Everyone can see, they claim, that this type of mechanism inevitably leads to interactions which are socially constructed on representations of competence, and that these are exclusively based on the level of equipment of the person's institution: *'it's because of a government decree […] that suddenly they're qualified. There are people who're competent for certain acts, and who perform them today, but who won't be able to do them tomorrow because of the decree'* (O, II); *'we're pawns without any weight'*.

The definition of competence criteria by actors other than themselves has caused healthcare professionals at 'lower levels' to feel that they are trapped in a system of disqualification over which they have no control: *'[…] I mean we don't wait for something abnormal before calling the paediatrician, we call them because it fits into a particular case provided for in the protocol […], because it's stipulated, even though the baby's fine, what I don't like about this system is that we're becoming robots …'* (MW, I). They consequently fear the loss of their qualification, mainly due to the loss of what they call 'practice'*: 'we're going to get out of practice'* (MW, I). And *'when there's hypertension or a serious toxaemia, if we never see any we won't know what to do, we won't know how it's going to lead to complications'* (O, I). Hence, Level-I and Level-II professionals feel they are caught in an inescapable process: *'And that's not a lack of competence in anybody, it's a problem of not being used to reacting very quickly to a particular problem'* (P, III). The practitioners of these levels mention the fear that's changing the way they practise: *'more and more we're going to transfer, we can't take risks anymore'.* They use many arguments to analyse the trap of uncertainty in which each of their decisions tends to be caught, and anticipate disastrous medical effects.

This first, clearly identified risk explains a second one: a gradual drift, already underway, from the technical impossibility of delivering a baby, to being labelled incompetent. This incompetence is visible to those who can perform the act: *'the change is the fact of watching the other person work'*, several doctors commented. And it is precisely because they feel subjected to the potential judgement of the technician (at Level III) that the lack of practice reinforces the feeling of no longer being able to assess a risk and to evaluate the real *'level'* of competencies that could be mobilized: *'we're going to change because of this outside look at us'* (O,I); *"and so they think we're incapable, they think we don't do a good job'* (O,I), *"because now we're forced to hand things over […] and to give the work to colleagues"*. In other words, *"we have superior referents who take care of our pathological cases"* (O,I). Level-III experts carry a heavy responsibility from this point of view, mentioned in the interviews: *"we're supposed to become the super cowboys of obstetrics"*.

The medical challenge is acute and the notion of emergency, in response to that of risk, leads the game and functions as the only focal point. Yet, as we have seen, the underlying principle of a network can function only if it is based on relations of mutual trust and reciprocity:

'the one who refers must do so with full trust' and, conversely, *'the receiver of a referral has to trust the one who referred, otherwise he or she could experience it as persecuting and excessive'* (O, II, future III). From the professionals' point of view, this reciprocity is based on an essential driver: recognition of the other person's work. Such recognition, the result of the practice of a profession, appears to be 'decisive in the dynamics of the subjective mobilization of a person's intelligence, personality and self-fulfilment' (Desjours, 1998), especially in the area of perinatal activity characterized by improvisation and uncertainty (which are easy to manipulate).
From this point of view the decree seems to destructure a series of informal links. Some doctors experience the modalities of these compulsory categories as something that *'destroys relationships'* between practitioners – relationships based on what many call 'habit', 'affinity', 'common sense', 'moral conscience of one's limits': *'we always decided on the spot, in a situation, in our soul and conscience'* (O, III). Many professionals say that their engagement and professional image have been acutely affected: *'others take decisions for us, we're not allowed to think […]; soon we're going to become second-rate midwives'* (O,I).

Hence, in the field in which the decree is applied, conflicts of interest and power struggles based on *'somewhat impassioned confraternal rivalries'* are developing. Our respondents maintain that formerly such conflicts were regulated through a set of transactional references that really worked.

Structuring the 'pathologization / surgicalization / judiciarization' schema.

Aiming for the maximal predictability of risks, as defended by the Decree, inevitably sets birth in the search for protection (albeit illusory) against the unpredictable. This has two immediate consequences: first, the increase in technical acts and medicalized interventions, now *'surgicalized'*, and second, the *'judiciarization'* of complaints and the dissatisfaction of parturient women. The planned and organized detection of *'problematical'* pregnancies tends to increase the anxiety-producing nature of childbirth.

Level-III institutions, described as *'big pathology factories'*, contribute towards maintaining a focus on the abnormalities related to childbirth (and its different forms of expression) and to *'concentrating pathological women'* in a high-tech space. Level-III midwives are particularly worried: *'women are going to find*

themselves surrounded by pathological pregnancies and […] you won't hear a baby crying anymore after delivery'. Many of those who work in these institutions express their concern about delivering almost exclusively still-born or deformed babies.

Hence, the notion of high-risk pregnancies, legitimized by these *'high security centres'* (which in turn justify the detection apparatus) establishes the habit of *'putting pregnant women under high-level surveillance'* and *'being wary of them'* in the sense that *'they can surprise one'* . In response, medical acts are 'normalized', as the steady annual increase in the rate of caesareans attests (Mamelle et al., 2002; Blondel, et al., 2001). As an obstetrician explains: *'they have so many tests, it's crazy, because it's compulsory. Just so that, if anything does go wrong, no one can say they didn't comply with … that's where we're going, for sure […] delivery rooms are being treated like operating theatres more and more… but what they don't know yet is that a caesarean isn't entirely harmless…'* (O,III).

Our respondents all agree that the increase in tests and induced deliveries is justified by the fear of error. A large majority of them feel, and regret, that they are accomplices in the instauration of 'preventive programming' that represents a real medico-psychological risk. Women seem to validate this medical power which they perceive as a guarantee against abnormalities. This type of reaction sustains the idea of the dangerousness of childbirth, thus consolidating women's feelings of impotence in this domain. Doctors' 'preventive' action, relayed by technological control, leads to women's dependence, with each party accepting and remaining within a prescribed role from which it seems difficult to break loose.

These few elements of analysis of our research material have furthered our understanding of why and how medical expertise is tending to be provided as a consumer good to which women can lay claim in exchange for the withdrawal and renunciation of their participation in decisions, or at least of their involvement in and understanding of what is to happen to them. Hence, the doctor/parturient woman relationship is formed in situations of emergency (emergency decisions, transfers, acts, interventions), in a mode of subordination. Caught in a spiral of 'precipitation', patients hand themselves over to the doctor's expertise, thus allowing themselves to be dispossessed of their own questions. The actual organization of transfers takes time, monitoring is tricky from a technical point of view, and the break with a familiar environment (the chosen practitioner) leaves little room for informing and

accompanying the patient as disillusionment sets in (giving up the idea of an ideal child, of an expected pregnancy). In the logic of such sacrifices, can the woman agree to give up the idea of the expected child (viable and normal)? This entire process maintains a medico-legal pressure that professionals experience as excessive and worrying, in so far as it rigidifies their prescriptive and interventionist attitudes in a defensive mode.

Should the child fail to meet the required standards, charges are laid. This is done at what seems to be the most appropriate level (the most regular one nowadays): legal action, or 'judiciarization', a form of mediation and attempt to disengage from the situation of subordination in the hope of recovering the right to speak. The objective is both compensation and the reappropriation by the parturient woman (and her family) of the event (and of the mourning of the expected birth).

In other words doctors, as service providers, refer to the values of medical expertise which is gradually tending to replace the tacit pact of unpredictability, while the patient is given (and demands) the status of consumer: 'the relationship of trust no longer exists, since we are service providers' (O,II). They perceive the serious and dangerous nature of this trend which the Decree both reveals and legitimizes, and which is progressively tending to subject medical decision-making to the medico-legal risks: 'we're going to take obstetrical decisions in relation to medico-legal [criteria] […] the relationship with our patients is slowly changing, and now we're starting to see the patient in front of us as a potential opponent in court' (O,II).

Parturient women seem to be losing a reliable support, but doctors are also losing the ability to be guided by their patients and to negotiate aspects of uncertainty.

Discussion

Setting Up the Mechanism of Over-Medicalization – Participative Avoidance and Inflation of Control

This analysis of the ranking of competencies and the pathologization and judiciarization of pregnancy shows that doctors, although they are convinced of the advantages of the Decree, have discerningly identified the implications of the situation and the regression that it represents for the practice of perinatal care. In their opinion, more fundamentally, the Decree proposes a perverted functioning of the network, visible essentially in the two symptoms

that reinforce the mechanism of over-medicalization, structure the power of expertise and participative avoidance, and extend control.

Our analysis of professionals' arguments shows that the Decree is imposed on the basis of a logic of defining pregnancy and the very subject of procreation, in medical terms. This tends to guarantee the exclusivity of medical authority and to identify individuals who have the legitimacy and qualifications to act as experts. The 'expertization' trend is legitimized by the adhesion of the mother, who is at the centre of the act (as an object of concern) but is not always positioned as a subject who talks and participates in the birth process – as regards 'the emergence of her needs and desires' but also the transmission of medical information on the course of the situation.

This situation stems from a dominant and consensual vision of a technical evolution based on the legitimization of 'prior action', equated to progress: *'one has to do everything possible', 'there's still (always) something to do'*. This type of spiral creates disappointment of equal intensity to the movement of adhesion and expectation.

The sequences of over-medicalization identified by professionals are designed to construct pregnancy as a programmable event and the child as a product. This is all the more so when the surgical act reinforces these objectives. M. De Koninck (1990) analyses how much the caesarean, 'by substituting the act of extraction for that of expulsion, and changing the passage through which the child leaves its mother's body, alters the definition of childbirth. The child, offered up to the mirror of medical imagery, and potentially malleable, is consequently evaluated within this process as a technologically successful result – or a 'flop'.

It is in this respect that the mother both submits herself and reacts. The practices of perinatal care, especially when they are precipitated by urgency, have proved to be the vehicles of idealizations/demands and relations of dependency and inequality.

This brings us to the second point of this mechanism of medicalization, concerning the limit and the guarantees of that limit. Healthcare professionals feel that they are confronted with a (deliberate) attempt to programme life (in total denial of any failure or lack), which, because it has not found its own safeguards, produces 'ad hoc' answers in a trivialization or fascination of life. At a deeper level, these interviews with professionals allow the emergence (perhaps the leaking out) of their fear of being caught in a spiral of mastery and control over life forms. Is there not a risk of the doctor-technician individual being trapped in a relationship with technology that manufactures humans, in so far as this technical act is deprived of

speech (or thought). As D. Vasse (1998) writes, this place offers itself as that of a misunderstanding, a crack in the sense of "a gap opening, that of a science which is unable to renounce itself in the legitimate will [. . .] of constructing the human being according to the knowledge that humans have of themselves". It is difficult not to be caught up in this game of imaginary substitution.

In other words, the over-caricatural positivistic instruction, 'save the child and the mother', on which justification of the Decree is based, clearly triggers the appearance of irrational and threatening behaviours. We may well wonder whether this passion for life masks a defence against destructive drives which, because they are not dealt with, undermine the organization from within. The description of competitiveness, rivalries, behaviours of domination, persecution and demands amply bear witness to this. They are all insidious forms of destruction which lead to the introduction of even more rigid measures to control risks themselves. Yet they generate even more risks, especially that of increasing the vulnerability of the actors of health and consequently of women.

Basically these safeguards that our respondents spoke about relate to the dimension of otherness but also, indissociably, to the law that assigns a place to it. Doctors say that in the logic of functioning of the network ('as it is'), with extremely arbitrary regulations, they cannot rely on their confreres without controlling them (or feeling controlled themselves). By positioning themselves in the logic of expertise, professionals are inevitably in competition with and cut off from parturient women. The harm experienced should also be recognized there where it cannot explicitly be expressed, other than in brief confessions, timid suggestions, arguments that are difficult to formulate because they could denounce the very foundations of medical practice.

The techniques of perinatal care oriented by the Decree, especially when they are precipitated by emergencies, have proved to be a source of relationships of inequality and dependence.

Conclusion

The Gap Between Political, Economic and Healthcare Logics

These different points indicate the consequences of a discrepancy between the injunctions of the Decree (prescribed 'from the outside') and real situations of healthcare and its organization, but also between economic and community logics: *'no one ever talks in financial*

terms and yet it's a huge problem". These inconsistencies impede the establishment of the healthcare and prevention network that the Decree aims for.

Even though practitioners explicitly state that they are not the agents, vehicles or deciders of this Decree, and that the means to apply it are lacking, they mainly highlight the many paradoxes and contradictions characterizing its content and the way in which it was imposed on the medical profession without those concerned having assessed its advantages or the utility and modalities of its application. It overlooks the real needs and the concrete, practical and subjective problems of prenatal care. These are anticipated, imagined and envisaged on the basis of arbitrary criteria: 'it comes from above' (MW, neonatal clinic). 'It arrived, just like that, from the ministry' (O,II). On some points it even goes so far as to disorganize former balances and to complicate structurally fragile situations.

But professionals' identification of points of dysfunctioning simultaneously points out ways to improve the system: participation by the actors concerned (including parturient women), shared management of responsibilities, and in-depth reflection on healthcare and medical interventionism in the name of progress. In this area, the latter issue is particularly crucial, complex and even ambiguous.

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