

The Philosophy of Respectful Maternity Care



Regmi K¹

¹Department of Obstetrics and Gynaecology, Paropakar Maternity and Women's Hospital, Kathmandu, Nepal.

The Medieval scientists, looking for the purposes underlying various natural phenomena, such as childbirth, considered questions relating to god, the human soul, ethics and modesty to be of highest significance. Before Rene Descartes, French rationalist and reductionist philosopher (1596 - 1650), most healers had addressed themselves to the interplay of body and soul, and had treated their patients within the context of their social and spiritual environment.¹

Taking it from there, I have a vivid childhood memory of Chitwan during the holy night of *Shiva Ratri*. That night was special, not only because millions of years ago the Lord Shiva was born, but also because I was served dinner early and, despite the late hour, I was set free to play outside the courtyard. It was special because it was not dark and scary like other nights. A pleasant spring breeze was blowing under the dazzling full moonlight, refreshing the whole atmosphere. I can still feel that soft light on my face. This night was special to me because that was the first time I had ever seen a 'dancing moon' over the Kirangi River that lies some fifty meters away from my home. Most importantly, that night was special because my grandmother was giving birth for the 13th time.

That afternoon, when the sun was still half-setting, some elderly neighboring women were busy preparing for the birth. They were making a fire in the fireplace, boiling water in a big aluminum kettle, heating mustard oil in a copper pan, and chanting tunefully. The sandalwood essence and the chants made the whole environment holy.

Given the importance of chants in Nepali childbirth traditions, it was not surprising that I developed special beliefs about the natural and supernatural forces which could alleviate childbirth pain. I felt so impressed that my grandmother did not cry out in pain like other birthing women. On that night, I was distracted from my usual play activities by flimsy shadows moving from one corner of the house to the other. I observed everyone through small gaps in the bamboo walls. The knots and bolts were absent from the door, but an angry looking woman was standing with a long stick in her hand. I was so frightened that I dared not go inside the house. Moreover, I noticed all the male family members sitting under a tree at the end of the courtyard. I tried to put my ear to the bamboo wall and discover what mysteries were going on inside but the angry woman chased me away.

Finally, there was something that could not be hidden: I heard a sharp but melodious sound coming from the house—a baby's cry. I rushed towards the door. I saw a pleasant-looking woman coming towards me. The woman's smile was wide and beaming like sunshine. She declared the birth of a baby; it was like a divine voice. I looked at the newborn and believed, in that moment, that it was truly a miracle, the most amazing thing I had ever seen in my life. It was a gift of the Lord Shiva. That was the notion of a 'spiritual childbirth' that I carried for years and years.

That outlook changed radically. Descartes' dualistic thought overthrew the views of classical medicine and replaced it with a scientifically-based logic in which the

CORRESPONDENCE

Dr Kiran Regmi
Paropakar Maternity and Women's Hospital,
Thapathali, Kathmandu, Nepal.
Email: regmikiran@gmail.com
Phone: 9845087900

The papers in this journal are published under the terms of the Creative Commons Attribution License. Users are allowed to read, download, copy, distribute, print, search, or link to the full texts of the articles in this journal without asking prior permission from the publisher or the author.

need for faith was superseded by rationalism.² With this rationalist-thought, medicine became a science and no longer remained the art of balancing the internal self with the external environment. That was the turning point of the childbirth from spiritual to technocratic.

Medico-legal pressure, not involving women fully in decision-making, and private practice are some other factors that play a crucial role in sustaining the technocratic childbirth culture.³ If professional midwifery texts are ignored, changes in cultural patterns of maternity service since the 1970s have been increasingly determined by the concepts of risk and security informed by a rationality based entirely on statistical data.

This intensity of technological scrutiny has consolidated a wider cultural acceptance of the conventional obstetric opinion that reproduction is 'normal' only in retrospect. 'Once a woman enters an at-risk category during pregnancy or labor, she becomes that category as a thing-in-itself as she is subjected to the overriding equation safety requires surveillance.'⁴ A woman seldom questions this safety requires surveillance equation.

In connection to safety requires surveillance equation, I envision my obstetric training in India as an orthodox 20th century technocratic practice which has squeezed the world of childbirth into a closed 'birthing suite'. That is to say the practices were constructed in imitation of the 19th century Victorian sealed birth chamber. In this practice, women enter the birthing suite and leave the whole world behind. If they must talk with their families (and this is usually discouraged), they do so through a small head-size hole situated at the entry point of the birthing suite. Most of the time in the labor room, medical residents use that small hole for gaining access to visitors. Often the doctors would scold the families for being uncooperative, but at the same time, they did not ask for their cooperation. Even in those early days of my training, I recognized the ways that physicians employ mechanisms of power and control.

During the whole course of labor, women were required to respond to several inquires about their obstetric history, as well as undergo uncomfortable birth preparations. These procedures were claimed to be evidence-based; for example, shaving and painting of the abdominal and perineal area, catheterisation of urinary bladder, soap water enema, penicillin test dose and an intravenous line. These activities prepared birthing women for the active management of labor. All of this had to take place in a special chamber of the birthing suite. There, birthing women had to lie on a bed, sometimes two patients sharing the same one with their heads aligned with one another's feet, like the queens in a pack of playing cards. In addition, many women were tied with a belt around their abdomens connected to a cardio-topography machine, the fetal heart monitor. Many others were not monitored by cardio-topography, and had to be ready for a half-hourly

monitoring of uterine contraction, and fetal heart rate. They had no time to recover from the deep-pressed pinard. The process as such is not painful, but is uncomfortable. Many women would not like it. However, some traditional maternity care providers are still comfortable to monitor fetal heart sound with this device.

Once the women entered into a second stage of labor, they were shifted to another chamber that had all necessary facilities with the expectation that they would follow the health workers' every command. From my perspective, the soul was missing from the birthing suite.

I recall one woman who gave birth in my hospital. Her whole uterus, together with a full-term baby, had prolapsed through the vagina. Somehow I managed to deliver the baby through a cesarean section. The uterus was still outside the vagina and would remain there probably for another week at least. I told her that she had to be hospitalized for at least another two weeks if she was going to survive, much less fully recover. Yet incredibly, the woman insisted that she had to return home immediately. 'That's impossible', I told her in my most authoritarian voice. 'If you leave this hospital under these circumstances, you will remain ill. You won't have other babies. You could even die.' The woman looked at me, nodded her head in understanding, but still insisted she must leave—as soon as possible. When I pressed her as to what could be so important that she was willing to risk her life, she told me that she had to go home because one of her goats was pregnant and she had to attend to the delivery! This is only one story to illustrate the cultural context of birthing experiences in Nepal.

I never imagined that I could deal with a subject that involves such close connections to human emotions and inner experience. After all, I had been taught to measure things and to keep distance from my patients as much as possible. Yet during the last few years that I have been listening to women, their families, and their health professionals. I have crossed into territory that I never imagined existed. If I looked at my position within the debate about the merits of being a 'lifesaver', I found it difficult to give a clear answer. As an obstetrician in my country, there could be many reasons for me to feel proud. In rural Nepal I have performed thousands of successful operative deliveries to save mothers' lives. As an anthropologist, however, I found myself struggling with my own convictions. In the process of performing my work, I have routinely separated women from their families by asking them to deliver alone in an 'unknown' labor room. In a sense, by focusing only on the uterus and birth canal, I have separated a woman's reproductive organs from the rest of her body. I had forgotten that a birthing woman also has a heart that is beating very nervously in reaction to some great uncertainties. All the times I was delivering babies and performing life-saving operations, I rarely, if ever, stopped to consider what that pregnancy experience was like for the woman.

REFERENCES

1. Cottingham J. Descartes: the great philosopher series. New York: Routledge; 1997.p.479-94. (Descartes: The Great Philosophers; vol 4).
2. Laura K. Mechanism and the representational nature of sensation in Descartes. *Can J Philos.* 1999;29:411-29.
3. Beech B. Over-medicated and under-informed: what are the consequences for birthing women? *AIMS Journal.* 2000;11(4).
4. Hackett M, Gee H. Role of the consultant obstetrician in the delivery suite. *J Manag Med.* 1998;12(2):101-8.