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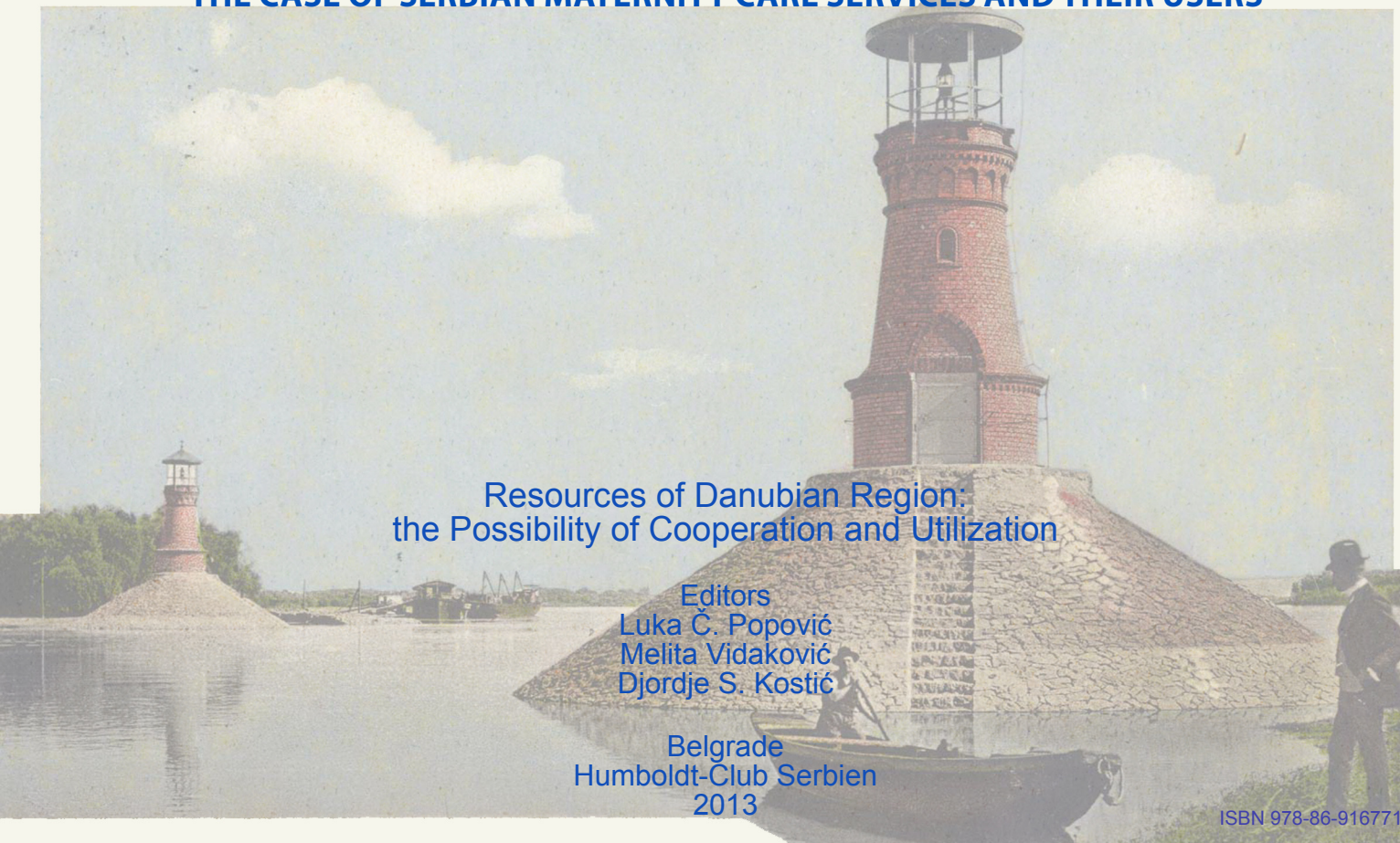
MEDICAL PRACTICE IN TRANSITION: THE CASE OF SERBIAN MATERNITY CARE SERVICES AND THEIR USERS



Resources of Danubian Region:
the Possibility of Cooperation and Utilization

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Abstract. Drawing on the evidence from everyday medical practice and experiences of women, users of Serbian maternity care services, this paper will tend to point to some of the important conflicts and inconsistencies that are being reproduced in Serbian health care system that is going through transition. Analysis will mainly focus on the gap between the creation of new policies and clinical guidelines and their actual implementation in practice, as well as on the unsynchronized transformation of different actors involved in medical practice that leads to tensions between sources of knowledge/models of practice in medical care.
Key words: healthcare system, health policy, clinical guidelines, medical practice, process of transition

Introduction: complex and incoherent character of medical practice

When we think or talk about *medicine*, we usually have in mind something that has been written in medical books or scholarly journals. There we find a broad range of medical knowledge – from reports about research results in different areas of biomedical science, to guidelines for best medical practice and information about new developments in medical technology. And when we think or talk about *medical practice* we tend to see it merely as an application of this always developing medical knowledge – that is, practical implementation of this knowledge to diagnoses and treatment of different health conditions in accordance with protocols and documents that suggest the best possible way this application should be done in real life conditions. In medical books and clinical guides, different objects of medical practice and clinical experience (that is different interpretations of one's health condition) are usually arranged to form a coherent whole. But the same does not apply to everyday life medical practice which is a mixture of different conventions, procedures, techniques, opinions, skills and instruments that have various regional variations (Berg & Mol, 1998). It thus entails multiplicity of interpretations of numbers and images, styles of interaction with patients, decision-making criteria, protocols of interventions and medical technologies in diverse institutional contexts. Where in textbooks the various versions of a disease tend to be neatly aligned to form a coherent overall picture, in practice there are gaps, fissures and frictions between different performances of any health condition - even if they go under the same name, the "diseases" diagnosed in different sites, do not necessarily coincide (Mol, 2000). If incoherence between various medical performances occurs in practice, some will be privileged over the others. Hierarchy established this way is not inherent to any system of medical knowledge. Rather, it is a product of hospital protocols, organization of the health system and other both policy-level and

individual-level decisions.

In this presentation my goal will be to point to some of the important gaps, conflicts and inconsistencies that are being reproduced in Serbian health system. During analysis I will be drawing on the evidence from different sources – policy documents and legislations, field notes from hospitals and maternity wards, interviews with women, users of Serbian maternity care services, who shared their experiences with me, but also, conversations with medical practitioners working as healthcare providers. But first, it is important to get acquainted with some important characteristics of local healthcare system and its organization in the area I will be focusing on.

Local context: transitory character of Serbian healthcare system

One really important characteristic of the local health system is its transitory character. The complex and incoherent nature of medical practice I discussed above is even more emphasized in today's Serbia where the health care system is going through transition. In many countries in transition, health reforms are part of profound and comprehensive changes in some essential social functions and values. But, what it is meant by this ''process of transition"? Some researchers of post-socialism have been criticizing understanding of social and institutional transition as a shift from one clearly defined state into another one (i.e. Verdery, 1996). They suggested being sensitive for new, special traits of social orders emerging in countries under post-socialist change. Therefore, if we study the changes that have taken place in post-socialist regimes of medical care and explore the novel challenges medical systems of these countries have faced in the course of the last one or two decades, it is important to note that transition is not merely a shift from one clearly defined state into another one, and certainly not solely a top-down organizational transformation.

Since a healthcare system consists of several levels, we would expect that the process of transition affects all of them – from health policy level (that includes legislations) and then institutional organization of medical care system (that includes clinical guides and official frameworks of institutional functioning), to the level of everyday practice (that doctor-patient encounters embedded in local institutional setting). But, as we will see, this process doesn't proceed with the same dynamic across all levels, and in many cases it takes different directions. For example, the process of transition involves the influence of EU regulations on pre-accession states' policies that are introduced from the highest level. But this still does not imply any direct change of everyday institutional practice on a bottom level. Even after the creation of new policies, a certain gap between the new policies and their actual implementation can be observed in practice. This important issue is going to be explored in more detail, because it is usually seen as an essential source of problems, inconsistencies and contradictions in today's reproductive healthcare in Serbia.

Besides, transition represents a really broad process that encompasses different actors involved, both medical practitioners and patients/users, and affects knowledge, attitudes and habits of both groups (Lock, Young, & Cambrosio, 2000). Sometimes, we don't have a synchronized transformation of different actors and that can lead to numerous problems and misunderstandings during their interaction and cooperation. I will come back to this important issue briefly at the end of the presentation and now I

will turn to more detailed analysis of the discrepancy between the policy level and the level of actual medical practice.

Discrepancy between the policy level and the level of actual medical practice

I Policy level: national goals and legislations

It is stated in the "National program of healthcare for women, children and youth" (2009) that ''health of women during pregnancy, childbirth and motherhood is one of the priorities of the health care system of the Republic of Serbia." Maternal health (together with child health) is usually taken to be an indicator of the health of the whole population, the level of development of health services, and even the development of society as a whole, and it is usually used ad a reference point when defining national goals in the area of health policy. As is the case in most European countries, during the last 20 years a steady decline in the birth rate is recorded in Serbian population, which also makes reproductive health an issue of national importance ("National Millennium Development Goals", 2006). ''White plague" discourse is thus commonly present in official documents and public debates surrounding the issue.

When discussing the quality of maternity care services official documents (such as "The national strategy for advancing the status of women and promoting gender equality", 2008) usually advocate an emancipatory approach to childbirth which involves: "humanizing birth by using new methods and techniques, developing mother and baby friendly medical institutions, (…) opening the possibility for the partner's presence during childbirth; developing alternative approaches to childbirth such as out-of-hospital and home births..." (p. 32).

So this highest level is the level of setting policy goals and delineating some general strategy. But the content expressed here of course can't be directly put to use in practice, it only marks direction and sets frames for a transformation of more concrete lower levels.

II Clinical guidelines and protocols

Fortunately, there were successful attempts to develop guidelines for good practice during pregnancy and labor which are intended to set standards for doctors' and midwifes' work. The guidelines were developed as part of the project on improving maternal and neonatal health in south-eastern Europe, realized in collaboration with other states from the region and with organizational, technical and financial support from 10 partner EU countries and 5 international organizations – most importantly WHO and the Council of Europe. The main aim was to ''raise quality of care provision in the field of maternal and perinatal health through the development of national standards, guidelines and protocols" ("Physiological Childbirth: the guide for doctors and midwifes", 2009). Serbian Ministry of Health initiated and supported the development of these guides that are been formulated by network of experts and that are sad to be:

- ✓ evidence-based – which implies that they refer to state-of-the-art research and clinical results;
- ✓ relied on recommended WHO standards and guidelines in this area of healthcare – that are being approved by International federation of gynecology and obstetrics and International confederation of midwifes and that are being applied in most developed countries for years;

✓ determined to answer to important problems of local medical practice (priority issues were taken from some studies of the current situation and from the expressed needs of women – maternity care service users).

Since I have a limited space, I will focus just on few clinical recommendations from a few most influential guides ("Physiological Childbirth", 2009; "Health care for women during pregnancy", 2005; "Care in normal birth", 1996) in order to be able to compare them with the situation in real medical practice. These recommendations cover few important aspects of care during labour:

a) *Informed consent:* It is stated that women should be properly informed about all interventions, medications and procedures applied and that their consent should be asked for.

b) *Support during delivery:* Partner's (or any other close person's) presence and support during delivery should be encouraged. Reports and controlled randomized trials investigating the effects of support during labor showed many benefits, including shorter labor, significantly less medication, better delivery outcomes and fewer cesarean sections.

c) *Position during delivery:* Encourage the woman to move freely around; allow the woman to decide which position to adopt during delivery, because frequent changes of position during labor can help her relax and cope with the pain. One position that is not recommended for longer stay is lying flat on the back. In this position, the uterus compresses the large veins that return blood from the legs to the heart, which compromises blood flow and may make contractions less effective.

d) Active management of labour (acceleration of labour): Active management of labour involves early amniotomy (artificial rupture of membranes containing amnitoic fluid) and oxytocin augmentation (administering hormone that stimulates uterine contractions) and is aimed to reduce the duration of labour as well as to prevent the prolonged labour. Although it slightly shortens the labour (approximately for one hour) and is associated with a marginally statistically significant reduction in the number of caesarean births (but only in some studies, other show no connection), it can cause a serious distress for both the mother and the child, although, the effects of labour augmentation on pain were not systematically studied. The difference in caesarean risk imply that to prevent one case of caesarean section 68 women would have to be treated with active management of the first stage of labour. Therefore, there is no justification to apply as a routine practice the policy of labour augmentation for preventing prolonged labour. It is sad that induction and acceleration of labour should be reserved for specific medical indications.

e) Episiotomy: Episiotomy is an incision on the perineum during second stage of labor and it is no longer recommended as a routine procedure. It was not proven that routine episiotomy reduces perineal damage and prevents other negative consequences. In fact, routine episiotomy is linked to a number of serious conditions, besides the fact that it is very uncomfortable for a woman and that it makes every-day functioning with the baby more difficult during the first period after the childbirth.

These clinical guidelines suggest appropriate ways of handling several important aspects of care during labour – management of delivery, appropriate interventions, favorable medical environment and basic terms that regulate doctor-patient relation. They are based both on the empirical/clinical findings and on the accepted ethical guidelines in other areas of medical care; and they have long since been broadly accepted and implemented in everyday medical practice in most countries of the western world.

III Level of everyday medical practice

Let me now turn to the level of everyday medical practice that is performed in Serbian maternity hospitals and examine in which ways it departs from the recommendations discussed above. The information about the common way of handling selected aspects of care during delivery is obtained mainly from interviews with women, users of healthcare services, but also from conversations with doctors, analysis of available documents and observations during fieldwork in maternity hospitals in Belgrade.

a) *Informed consent:* Typically, women are not informed about which interventions, medications and procedures are going to be applied. They very often report that doctors perform amniotomy without prior notice and that they are given induction drugs or sedatives without their knowledge or consent. Also, it happens that they get total anesthesia without notice during the third stage of labor in order to perform manual exploration of the uterus. The only intervention for which their written consent is asked for is caesarean section.

b) *Support during delivery:* Father's presence at childbirth is possible in only 10% of maternity hospitals in Serbia (which practically means in only 5 or 6 hospitals, since there are 58 of them). It is not allowed to be accompanied by any other person except the father (in this few hospitals) – relative, friend, or doula. Some hospitals require a fee to be paid, because father's presence is recognized as an additional (and exceptional) service. Father is also always required to perform multiple analyses to verify his health prior to attending birth, which is not just unusual, but virtually unknown procedure in other countries. Head of the largest maternity hospital in Serbia in an interview for the biggest Serbian daily newspaper, said: "In principle I am against it, but I can't do anything to forbid it." This example is a good illustration of the general attitude of Serbian medical community regarding the father's presence during childbirth.

c) *Position during delivery:* Lying on the back is the most favored and usually even the only possible position the women can take during labour. Turning on one side is allowed only when symptoms resulting from lack of oxygen and problems in circulation occur. Even walking around during first stage of labour is made extremely difficult by the fact that all women (with few exceptions) have infusion administered, which implies that one or both of their arms are connected to medical equipment. Sometimes, oxygen is given through the nose (with nasal cannula). Sometimes women report that they feel like cyborgs, that they are tided with bunch of cables and can not move. On the other side, lithotomy position is greatly favored among medical practitioners and is even recommended in medical handbooks that are used in university medical education.

d) Active management of labour (acceleration of labour): There is a general agreement among medical professionals in Serbian hospitals that for primiparous women early amniotomy and oxytocin augmentation are necessary in 100% of cases, because these procedures shorten the duration of labour. Active management and acceleration of labour is common institutional policy in all maternity hospitals in Serbia and delivery is never left to advance spontaneously (except when a woman is having a rapid labour). Even pregnant women perceive these procedures as useful and necessary because they are told that otherwise the labour would be too long and more risky for both the baby and the mother.

e) Episiotomy: Episiotomy is also performed routinely for primiparous women and its rate exceeds 90% in Serbian maternity hospitals. It is for decades believed that this procedure reduces perineal damage

and facilitates the expulsion of newborn's head and this attitude is transmitted to every new generation of physicians, although this is no longer supported by clinical research findings.

It is clear that there are substantial discrepancies between the policy level and level of recommended guidelines and protocols on one side, and real medical practice on the other. It seems that a hospital, as a micro-level with its own relative agency, can have significant ways for reshaping the new macro-level revisions to a degree that the more common, former medical experience is perpetuated and reproduced. At the end, let me outline some possible factors that could lead to these consequences.

Conclusion: possible causes of discrepancy

As previously mentioned, unsynchronized transformation of different actors involved in medical practice leads to tensions between sources of knowledge or models of practice which result in encounters and conflicts between local and global medical knowledge or practice, and expert and lay one. I already pointed out the transformation of policy makers that was induced by external pressures from the highest level of policy to align the content of medical care services with the other European countries. In the next step, this also led to development of the clinical guidelines for good practice during pregnancy and labor which are intended to set standards for doctors' and midwifes' work. However, real everyday practice of medical practitioners remained unaltered and I would like to tackle this issue briefly. But let me first turn to the transformation of women – patients/users of health care services.

Generally, over the last few decades, the relationship between doctors and patients has changed dramatically in most areas. The paternalistic approach, that is seeing the patient as a passive recipient of the care prescribed by the doctor, who 'knows best', has changed as the autonomy of patients has come to be seen as an important factor in their care. They are acknowledged as having a right to be kept fully informed about the options for care and to take part in shared decision-making (Savage, 2003). Among other things, this transition is encouraged by the changed socio-historical circumstances that enable easy access to medical knowledge that became available due to greater use of the internet and is no longer the exclusive privilege of medical professionals. As a result, labouring women are transformed from patients to users of healthcare services (Akrich & Pasveer, 2004). Before coming to the hospital they are really often fully informed through the use of books, articles, preparatory courses, internet discussions with other women, professional websites (Thompson, 2005). As a consequence, they are ready to challenge the knowledge and practice of local health practitioners. And the resulting tension is not the one between lay and expert knowledge, but the one between two types of expert knowledge – in the case of Serbian medical system – between traditional and contemporary one.

So, as it looks like, present medical practice is challenged from both higher level of state policies and recommendations, and from lower level of changed group of users who are the advocates of contemporary expert knowledge. And, unfortunately, medical practice is usually challenged without success. Since, in our conditions, it is mainly dependent on the agency of healthcare practitioners, I'll try to give a brief overview of factors related to this group of actors that could prevent the above-mentioned challenges to be effective.

The primary and secondary socialization of medical practitioners has remained unchanged. That means that the knowledge and professional training they receive during studies departs substantially from the present research and clinical results. After that, they start working in professional environment that is again dominated by traditional models of practice. These conditions make this particular group of actors particularly resistant to change.

The unchallenged status of medicine as an elite profession that has an exclusive jurisdiction over all issues concerning the body is not helping either. It usually prevents women to confront their physicians directly when they are certain that particular intervention is not justified and is against their best interest.

Finally, I wish to emphasize that I didn't report here about cases of neglect, errors, or non-professional practice - although there are a lot of instances of this nature – among other things because of the closed and non transparent nature of Serbian medical institutions, elite status of physicians, non-existent or poor monitoring and evaluation practices and the like. I also didn't talk about the cases of bad practice as a consequence of the lack of resources and adequate technical means (as is for example epitomized in the Serbian version of Baby-friendly initiative, but that has to stay out of the scope of present paper). I talked about the practices and procedures that are regularly and legitimately applied, with the support of the local professional community and in good belief that they are examples of good practice.

My aim was to open a debate about certain problems and inconsistencies in our medical system that might not be seen from the bird perspective, but are very obvious from the concrete experience with local medical practices. I also hope by this to draw attention to those specific weak points of our healthcare system that would especially benefit from certain resources that could be obtained from cooperation with other countries from the region which faced similar challenges in the past and overcame them successfully.

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