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Teaching midwives about physiology-based care: going beyond the core curriculum

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Molly O'Brien

A discussion with Molly: what I learned - By Alex Smith

A few weeks ago I enjoyed the privilege of a long phone call with Molly O'Brien. Molly is a childbirth preparation teacher, midwife educator and a registered midwife. Her career of over twenty years has been based on her passion for enabling normal physiological birth, and she is currently very much in demand running workshops for midwives to help them do just that. I called her to ask about these workshops.

Molly explained that the course is called 'Biomechanics for Birth'. It focuses on ways that midwives can recognise when the birth process goes awry due to a mechanical issue. Any kind of prolonged labour (as defined in the medical model) is known as labour dystocia, and is often given as a leading reason behind high intervention rates, traumatic birth experiences, including forceps and caesarean birth for first time mothers. It can cause great distress, increased pain and exhaustion, yet it is poorly understood and under researched. The baby's position is cited as one of the causes of prolonged labour.

However, Molly has discovered from her own experience, from listening to women, and from her observation and study over the years that a baby who is in a suboptimal position is a consequence, not a cause of labour dystocia (Ed: if we understand that labour can be delayed in the very early preparatory

phases even before the onset of noticeable contractions). A mechanical imbalance in the pelvis can create a reduction in space meaning the baby may have to position itself in angles that don't fit best for that mothers' pelvic shape. When recognised early, and with a better understanding of the anatomy (mechanics) of the living (bio) pregnant body, the mother can be helped to move in ways that make more space for her baby. In this way, a longer, more painful labour can be averted.

While the course teaches techniques to midwives, Molly stressed that these are not yet more things that are done to helpless women by 'expert' others. Her belief is that women can generally give birth unaided and that the power balance should lie with the mother who can utilise these techniques to help herself and her baby have a birth that is safe, positive and joyful. Indeed, when completely unobserved, women probably use these movements instinctively, but, in the presence of even a friendly supportive midwife, cultural conditioning overrides instinctive behaviour and the woman defers to the midwife. The midwife, however, can return agency to the mother by creating the right conditions and by inviting the use of these techniques when the mother seems to need them. Molly says that everyone working in the birth world should know this information and that resolving a difficult or obstructed labour using the gentle and harmless approaches of biomechanical understanding, should be part of midwifery and obstetric training[1].

I asked Molly why she felt that midwives were not already taught about the knowledge that underpins biomechanics. She then spoke about birth as a feminist issue with the medical model of birth being one that has arisen from the subjugation of women over previous generations. Not only are women in labour under the control of 'the system', but so too are midwives and therefore their training will naturally support this status quo. Molly said that an understanding of biomechanics alone is not enough to improve women's birth experiences. Her course encourages midwives to re-evaluate their perceptions of birth and to challenge the status quo. Listening to the woman, valuing her knowledge about how the baby is passing through her pelvis and validating her experience is essential. She says that, "The essence of the course is "Biomechanics for Birth", but its context is the political agenda of the maternity and childbirth arena."[2]

Finally, I asked about what actually happens on one of her courses for midwives. Molly explained that the course lasts for seven hours. There is also some important pre-course reading required about the relevant anatomy and physiology. In the morning, Molly leads the group through the story of a woman with a longer and painful prodromal labour[3], exploring her labour and birth journey through maternity services within the medical model where the majority of women give birth. At each turn of the story participants discuss and critically analyse common practices, solutions, evidence and effectiveness. Participants discuss a different way of observing, using watchful attendance, without depending on some of the more intrusive and intimate examinations like vaginal examination. Later, discussions are developed on how best to support and optimise the physiological process using biomechanical techniques and freedom of movement in the birth room, placing the woman at the centre of care.

The afternoon session focuses on teaching specific biomechanical techniques and positions.

On her website, Molly lists the course content:

- Definition of labour dystocia, suboptimal positions, statistics and birth outcomes
- Applying Biomechanics to birth including anatomy and physiology, causes of dystocia, who has a higher chance and why, and how to recognise it in a timely manner to increase the chance of a positive birth experience.
- Practical techniques including instinctive and flexible sacrum birth positions[4], the use of rebozo[5] and positions to help labour progress such as forward leaning inversion, side lying release, abdominal lift, modified exaggerated lateral position, birth balls and peanut balls
- Techniques to improve diagnosis of a mechanical issue complicating the birth process
- Other helpful strategies that support physiological birth
- Empowering midwifery and challenging the status quo
- Research and evidence
- Communication, consent and documentation

I wondered whether course participants were putting their learning into practice and if so, whether they were seeing real differences. Molly told me that midwives and obstetricians around the country are excited at the results they are seeing when using the techniques. Audits are being carried out in several NHS Trusts and preliminary results show a reduction in instrumental births and severe perineal trauma, and an increase in better birth experiences.

While there has not yet been a formal evaluation of the training Molly offers to midwives and healthcare professionals, she is encouraging each participant to record at least three case studies of births that have included use of the techniques taught in the course. She uses these in an advanced course to help build a useful anecdotal picture of how biomechanical techniques can influence the course of labour. More immediately, and very importantly, midwife feedback about the course is excellent. The reviews include comments about how practical and interactive the day is and one respondee wrote about the course:

> I feel it has brought me back to being a midwife rather than an obstetric nurse

Listening to Molly's passion and enthusiasm for "supporting and preserving normal birth"[6] I was left feeling very heartened. Molly shares the same goal as AIMS[7] in wanting to see more women have a

positive experience of maternity care, and her work is a vital contribution to change the conversation in childbirth.

Molly O'Brien: Molly worked as a clinical midwife in the NHS for 20 years. She is now an associate lecturer, birth preparation teacher and freelance trainer. In the course of her career she developed techniques to diagnose and rectify labour dystocia. She teaches online and travels all over the world teaching her Biomechanics for Birth course.

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1 Editor's note: Prodromal labour is the term given to the fairly intense period of non-progressive pre-labour contractions that many women experience.

2 Molly's website - https://www.optimalbirth.co.uk/index.php/blogs/biomechanics-for-birth-a-labour-of-love

3 Editor's note: This refers to positions of the mother that allow for the optimal flexibility and opening of her pelvic bones. This flexibility is impeded when her sacrum (the back of the pelvis) is pressed against the bed.

4 Editor's note: Rebozo is a practice that refers to a long scarf of the same name worn by women in some South American countries. Amongst many other uses, it has traditionally served as an aid in labour. https://www.aims.org.uk/journal/item/rebozo-in-an-nhs-setting

5 Molly's website - https://www.optimalbirth.co.uk/index.php

6 AIMS position paper on Physiology-Informed Maternity Services. https://www.aims.org.uk/assets/media/730/aims-position-paper-physiology-informed-maternity-care.pdf and AIMS Physiology-Informed Maternity Services campaign. https://www.aims.org.uk/assets/media/818/campaigning-for-physiology-informed-maternity-services.pdf

7 Editor's note: Molly has identified an important gap in midwifery training. It should not be down to chance or choice whether or not a midwife develops this knowledge. As service users, we expect any midwife attending us to have this knowledge and skill set. The AIMS position paper says, "Both initial training and continuing professional development for all maternity services staff should focus on promoting an understanding of physiology and a holistic view of safety". We ask how this perceived gap matches up with the (pre registration) NMC standards and the (post registration) Core Competency Framework.