AIMS For a better birth...

Normal Birth in Ireland

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Declan Devane challenges us to embrace change and to make birth normal

After some very difficult years, there is a growing commitment to normal birth in Ireland with midwives feeling that we can make a substantive impact for the better. Our first conference on Normal Birth organised by Cuidiú (the Irish Childbirth Trust) last year was oversubscribed, indicating how strong the determination and commitment are to achieve real change.

Normal birth is an important topic for women and for all involved in the provision of maternity care. It is particularly important to midwives because it is the focus of our attention, it is at the heart of our skills and expertise; it is what defines us as midwives. Yet we have had a clear problem in holding on to this vision of our skills. In Ireland, historically as midwives, we enjoyed an honoured place, especially in Celtic Ireland. At the same time, women in a predominantly rural setting down to the 20th Century were deemed well able to give birth. Evidence for this is found, for example, in the work of James Wolveridge, a physician who wrote in the seventeenth century praising Irish women for their 'hardiness' in giving birth. This is what he wrote in 1670 in his Speculum Matricis Hybernicum; Or, the Irish Midwives Handmaid:

'there is scarce one barren among [the women]; [their] hardiness, and facility in bringing forth, is generally such, as neither requires the nice Attendance of diligent, vigilant Nurse-keepers, or the Art of expert Anatomists, or the unwearied pains and skill of dexterous Midwives ... '

As hospitalised birth became the common mode in the 20th century, normal birth became a less frequent occurrence, especially in the closing decades of that century. In the last decade alone, the rate of caesarean section in Ireland has increased by over 72%. Have women lost their 'hardiness'? As midwives have we lost our 'dextrous skill'?

In 1991, for every 100 women that gave birth, 73 had what is termed a 'spontaneous' birth. In 2002, for every 100 women that gave birth in Ireland, approximately 62 had a 'spontaneous' birth, 22 had a caesarean section, 10 had a vacuum birth and 3 had a forceps birth.

That just over 6 out of every 10 women are having 'spontaneous' vaginal births is a cause for concern in itself. However, of equal concern is what we actually mean by 'spontaneous birth'. When we say 'normalbirth' do we mean a 'spontaneous birth' or vice versa? The World Health Organisation defines normal birth as:

'...spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks gestation. After birth mother and infant are in good condition'

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But perhaps this definition is too broad? Many have argued that it is. Within this definition, a woman who has had continuous electronic foetal monitoring, her labour accelerated by artificially rupturing her membranes at 3cms, an epidural, perhaps an oxytocic infusion to ensure adherence to the partogram, an episiotomy and who gives birth half sitting-up, half lying down would be regarded as having had a 'normal' birth. I am not so sure I would agree. I know this is a rather extreme example but how many of us have cared for a woman without risk factors who has had a CTG at any point during her labour, an ARM, a syntocinon infusion, where the mother's pushing efforts are directed and, in the end, where this package of measures is regarded as a normal birth? Few, if any of us, could say we have not encountered this, that we do not encounter it on a daily basis.

What is 'normal' about this? What is wrong with this description of childbirth care? Can we call it 'normal' now that the majority of women have some intervention in labour and birth? Why has such a strong focus on intervention become acceptable? Why don't more women have normal births? Where is the evidence that this intervention intensive model of care does more good than harm? What is normal birth? I wonder if we really know anymore.

Today, intervention has become routine in normal childbirth. I have asked myself why, as no doubt midwives across Ireland have asked themselves, many times. Women have either become incapable of giving birth without routine intervention or routine intervention is being used on many women unnecessarily and without benefit. I believe the latter to be true.

We hear much talk of philosophies of pregnancy and childbirth with the social model of childbirth as a normal physiological process being attributed to midwives and juxtaposed with the medical model where pregnancy and childbirth are pathological conditions, only normal in retrospect and certainly requiring intervention if a 'successful' outcome is to be achieved. I don't see things quite so simply. Certainly, some women will require intervention in childbirth and will benefit from the use of appropriate intervention. Not all midwives will see birth as a normal, physiological process and not all obstetricians will see it as pathological event. At the same time, when midwives and obstetricians wage war, women suffer.

Midwives and obstetricians alike, like to see ourselves as autonomous practitioners, respected for what we do and accountable for our own actions. But often the environment, the bureaucratic structure and the power imbalances in which we work mitigate against our providing what we know to be best practice. Never theless, routine use of intervention in normal childbirth is not empirically, financially or morally defensible. This holds true for all maternity care providers, midwives and obstetricians alike. As midwives, we know we have an obligation to provide evidence based practice. Moreover, we know we are obligated to do so by virtue of the Guidelines for Midwives and the Scope of Professional Practice from An Bord Altranais, the Irish Nursing Board.

No intervention can be so good that it should be administered to all women regardless of need. As a midwife, where you know of practices that are routinely administered to or performed on all women, ask

yourself how individualised the care is and what the evidence for the intervention is. We are accountable for our OWN practices. Each routine intervention in normal childbirth adds more costs to care, has potential adverse effects for mother and baby, necessitates use of still more interventions and, importantly, takes away from the time we have to provide care for women. No evidence suppor ts the routine use of the admission CTG for women whose infant is not at risk of intrapartum hypoxia. On the contrary, what evidence is available suggests that the admission CTG at best confers no benefit for mother or baby and, at worst, increases the caesarean section and instrumental vaginal delivery rate without any improvement in neonatal outcome. I must ask who performs the admission CTG?

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No evidence supports criteria for interpreting the CTG trace that has been performed on the 24 week foetus. I ask who puts on the CTG?

No evidence supports the routine recording temperatures, pulse, blood pressure. I ask who does it and why do we do it?

No evidence supports routine postnatal fundal height assessment. I ask who does it and why do we do it?

No evidence supports arbitrary timings of the frequency of vaginal examinations during labour. I ask who performs these examinations?

No evidence supports routine induction of labour for post maturity prior to 41 weeks gestation. I ask who fails to challenge the rationale for such an induction?

No evidence supports daily or even twice daily CTGs for mothers who are in hospital with placenta praevia or unstable lie. I ask who performs the tracings and what is their rationale for doing so?

I am sure midwives can think of many more examples.

Where then does this leave us as midwives in protecting and promoting normal birth in Ireland? Can we say confidently that we are providing care that is based on the best available evidence and that will maintain the best interests of the women and infants we care for? I think we need to ask the difficult questions. I know that hospital policies, tradition, authority and fear can dictate practices in the face of better evidence showing the practice to be, at best of no benefit, and, at worst, harmful.

This should not be allowed to continue and this decision is ours to make. We will not provide care that is not based on the best available evidence. Maternity care is changing in Ireland and changing for the better. Charles Dickens's words from a distant time and a distance place have echoes for us in the Ireland of today:

'It was the best of times, it was the worst of times,
it was the age of wisdom, it was the age of foolishness,

it was the epoch of belief, it was the epoch of incredulity,
it was the season of Light, it was the season of Darkness,
it was the spring of hope, it was the winter of despair,
we had everything before us, we had nothing before us ... '

Some midwives may think that I am idealistic, that the maternity care I speak of is nothing but a dream. Yes it is a dream, but no, it is not idealistic, it is a right! Every woman has the right to expect care based on the best available evidence and every midwife has the obligation to provide it. So where can 'ideal maternity care' be found? Wherever women are treated as individuals and receive the best care from the most appropriate professional. For some women this will be within a midwifery-led model of care. For others, this will be within a consultant-led model of care and for yet others this will be within a shared model of care between midwives and obstetricians. The harmonious provision of these three models of care is my dream and I hope to see it in my working lifetime.

Where is the ethical and professional imperative of all maternity care professionals to provide evidence based care? When will all maternity care become consistent with evidence-based care? When will today's standard of care no longer be acceptable? Childbearing women deserve much better care than they are currently receiving; midwives have the right to provide such care and should suppor t each other in doing so. If we only strive to change government policy, we fail. If we can change minds and change behaviour, we will succeed, but it will be difficult.

My hope in articulating these thoughts is, if nothing else, helping to support midwives in questioning and perhaps changing. When I think of childbirth in Ireland I do feel that it is the best of times, it is the worst of times. Thus I feel both a sense of profound fear and extraordinary hope.

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Reference

1. World Health Organisation (1997). Care in Normal Bir th: A practical guide.Repor t of a Technical Working Group. Geneva,World Health Organisation.