AIMS For a better birth...

Home Birth and Normality

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Midwife and mother of two Sarah Davies reflects

I have two children, now in their teens, both born at home. My first labour went on for a long time. Labour stalled at 6cm dilatation for 12 hours, but I was healthy, had a supportive midwife and my family and friends around, and knew that both I and the baby were OK, so it was just a question of gritting my teeth and keeping going (as well as cuddling in bed with my partner for a while.)

I was a midwifery teacher at my local hospital, known for my enthusiasm for home birth, so when thoughts of escape (i.e. hospital admission and an immediate caesarean section) crossed my mind, I thought about how some of my colleagues would be saying 'told you so', also realising that in fact there was no rescue from this phenomenal process. I then somehow accessed new energy and determination: eventually and triumphantly, I gave birth to my daughter, and was on cloud nine for weeks. We never worked out why my labour had gone on for so long (52 hours in all) - was it the short cord, was it something psychological, or was this simply normal for me?

For the birth of my son three years later, I opted to use a birthing pool. Labour progressed quickly. The midwife, an experienced and wise colleague, listened in and we both heard a fetal heart of about 60 (half the rate of normal.) She looked me in the eye and said 'you know why that is, and I know why that is.' Indeed, we both knew that the slow rate was my baby's response to the compression of his head as he came quickly through my pelvis, and that it was nothing to worry about. No panic. I got out of the pool, because it felt cold. My son was born on dry land, a little blue and floppy, with the cord around his neck, but we left the cord to pulsate so that he received his full complement of blood from the placenta. Gradually he began to respond and we all greeted him; another wonderful birth.

However, depending on the experience and viewpoint of the clinician, these physiologically normal births could both be seen as having elements of abnormality, (prolonged labour, abnormal fetal heart rate.) Indeed in any obstetric unit in the UK, my first labour would have undoubtedly ended in a caesarean section for 'failure to progress'. I am inclined to wonder how many women's pregnancies and births in the current climate are deemed 'normal', and to consider how problematic the concept of normality can be. After all, the role of the midwife in normal birth was set down by doctors in the early part of the 20th century as they decided to leave to midwives the 'tiresome and unremunerative work'[1] of attending normal birth! In those days, twin and breech births were seen as normal events, and took place at home. So normality is a changing and changeable concept, one that has been captured by an often nervous and unreflective obstetric establishment, and one that many women and midwives are now trying to

redefine. As a midwife who attends home births, I see how amazingly adaptive women's bodies are; how so often women know intuitively what to do when events are not quite straightforward.

Billie Hunter's evaluation of the All Wales Clinical Pathway for Normal Birth (NLP) gives insight into the complexity of the notion of 'normality' 2. The NLP is a three-part document which acts as a protocol for midwifery practice, with the aim of supporting normality in labour and reducing unnecessary interventions. Implemented throughout Wales in 2002-2004, it is a brave and important initiative which has brought normal birth centre stage; but so far, surprisingly, there has been no increase in the rates of normal birth. The problem with defining normality may be that such a definition can become restrictive - women are either 'on' or 'off' the pathway and the 'grey' areas are no longer included in the realm of 'normality'. Some of the midwives Hunter interviewed said that the pathway resulted in a rigidness which undermined their clinical judgement. Women themselves described varied understandings of the meaning of the phrase 'normal birth', seeing it as an individualised concept and emphasising the differences.2 Pregnancy, labour and birth are an individual journey for each woman, often characterised by uncertainty and complexity; therefore teamwork and consultation between clinicians is necessary to achieve best outcomes.

To give an example of the importance of teamwork in achieving positive birth outcomes, I would like to tell a story of genuine collaboration. I supported one of our midwifery students, Eva, for the planned home water birth of her fourth baby. She chose to give birth accompanied by her husband, her best friend Sharon (another student midwife) and myself, her midwifery tutor. Eva's third baby had been delivered by caesarean section for an unstable lie. Early on in Eva's pregnancy I wrote to the consultant obstetrician asking for his support should we need medical referral, and received a positive response. I talked with my supervisor of midwives, who introduced me to the supervisors who might be involved should we request support or if Eva transferred into hospital. We all knew who was who, and we all had the same aim - that Eva should have the birth experience she wanted.

When Eva went into labour, there was old meconium in the amniotic fluid, so we noted it as a sign of a mature fetus, and made sure we listened to the fetal heartbeat regularly. The presence of old meconium only indicates greater risk where there is also an abnormal fetal heartrate. Eva had a long first stage, and at one point I was concerned about progress as the baby's head was still high despite good contractions; Eva and I were both wondering about transfer to hospital, so I rang the supervisor of midwives on duty and we discussed the whole labour in detail, deciding that it would be a good idea to allow more time and then review the situation after an hour or so. What really struck me about this conversation was the supervisor's complete support for Eva's choices and the way this guided her response. This supervisor had never met Eva or me, but her primary concern was for this woman's experience. This telephone discussion ensured that Eva had the birth she wanted: at home with her family around her, Eva gave birth to a beautiful baby boy. She had had a previous 3rd degree tear and again her perineum needed expert repair, so she went into hospital where the registrar repaired her perineum with skill and kindness, supported by the midwifery team, and soon she was back home.

When I discussed the birth with the supervisors of midwives afterwards, they were truly delighted for Eva. Throughout the pregnancy and birth, there had been no negative mutterings about risk, or attempts to 'encourage' Eva to give birth in hospital. From my perspective, this was supervision and teamwork at its best. If I had been undermined and unsupported I would have felt anxiety; this would have been sensed by Eva (labouring women are exquisitely sensitive to the emotions of their attendants) and this awareness would have caused her own adrenaline levels to rise, hindering the smooth progress of her labour.

Eva and her baby were best cared for through having as little disturbance to the labour process as possible, through unobtrusive observations, and by having supportive companions - not just in the birth room itself but within a wider network of supportive relationships. When Eva needed medical assistance, this was provided seamlessly and with the same respect for her autonomy. This kind of care should be provided wherever women find themselves, and whether they choose to give birth at home or in hospital.

As Downe3 suggests, perhaps now is the time to move away from the 'sterile debate of trying to define and reify "normality" which attempts to classify an "ideal" type of birth and what "is done to" women (...) towards seeing women as individuals with agency, and with a subjective sense of choice, power and control regarding childbirth.' So where does this leave the clinicians who care for women in the climate of an increasingly risk-averse society? The only possible solution, it seems to me, is teamwork: where women's agency is central, but where clinicians also have mutual respect for each other's expertise. The need for mutual respect has been emphasised by recent Health Care Commission Repor ts, which identified 'tribalism' between doctors and midwives as a reason for poor care, finding that they did not see themselves as sharing the same goals.4

It is time, perhaps, to reiterate that all of us, clinicians and parents, have the safety of mother and baby as our central aim. Safety must be understood in a holistic sense that encompasses physical, psychological and spiritual safety. Perhaps we need now to include in our understanding of safety the 'existential' safety each of us feels when we trust, and are trusted; this is what helps birth progress smoothly. Where I teach midwifery (Salford) we are now focusing upon 'multiprofessional teamworking' as a way of improving maternity care. Basing our approach on that pioneered by Sally Pairman in New Zealand, we are beginning to explore ways of ensuring that women, their partners, and childbirth activist groups are central to our curriculum.

Student midwives carry a caseload (their care in future to be evaluated by the women themselves.) AIMS, ARM, NCT and home birth groups collaborate, while enthusiastic midwives and super visors work to promote women's freedom in birth. Mutual respect between midwives and doctors is of crucial importance. For example, working alongside the midwives and physicians, one of our local obstetricians recently actively supported a woman with insulin dependent diabetes to achieve the home birth she wanted. This woman is now chair of the MSLC and regularly lectures to students, midwives and obstetricians.

Hierarchical relationships do not encourage safe care; the key change needed is to foster assertive communication between all involved in order to create mutually respectful relationships. Clinicians need to understand that risk and safety are in the eye of the beholder[5] and will be viewed differently by different individuals depending on their life experiences. Rather than being feared, these differences in perspective should be respected and valued.

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