AIMS For a better birth...

Negotiating a Normal Birth

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Nadine Edwards discusses some of the negotiations women face when planning a home birth

The following article is based on a talk at a conference entitled, There's no place like home: birth at home, organised by the Maternity and the Newborn Forum, Royal Society of Medicine, in London on 27 Sept, 2007

Negotiating a normal birth at home

There are a number of assumptions made about home birth that might be useful to look at more closely. They are that:

- women in Britain can plan home bir ths if they wish - they have a right to birth at home, and the community midwifery service is there to support them
- women are in complete control at home
- home birth is synonymous with normal birth

Some women say that this is not quite so straightforward as it might seem. First of all there are a number of obstacles to booking a home birth.

Planning a home birth

Negotiating home birth: with partners

Women often abandon the idea of home birth if their partner is negative - which is quite likely because often partners

- have absorbed the cultural fear of birth
- assume hospital birth is safer
- lack information - they haven't read the research
- want to do the best for their partners and babies
- have no reason to question doctors
- don't know that midwives are skilled and carry equipment to respond to emergencies and will arrange transfer to hospital if necessary

Women don't like to challenge partners too much. They might not feel completely confident themselves, and because of the dominance of the nuclear family, they don't want to alienate the very person they

might most have to rely on to support them looking after their children. It is easy to understand why women whose partners are not keen on home birth abandon the idea. It's difficult and the benefits are uncertain unless they've had a home birth before. It's typical for women to say that they thought a home birth would have benefits:

'but it's not 'til it's happened that I'm clear about what those are and actually they're much more about positive things than just avoiding hospital. I'm much clearer about how awful hospital would have been for me.'

Typically, following a home birth women talk about feeling safer, freer and less inhibited during labour, having people of their choosing with them, enjoying the relaxed time after birth, feeling more confident, elated, and really proud of themselves, enjoying long term positive impacts on them and their families, and say that all these things would have been much less possible in an institution.

So, rather than following the rules of our individualistic consumerist culture which says, 'it's your choice' and then adds, 'but your partner needs to support you,' women need support from midwives to reassure their partners, because this matters to women and once engaged with the issues, most partners become extremely supportive.

Negotiating home birth with GPs

Many women still assume they have to book with a GP. They don't know that they can book directly with midwives. Many GPs

- have also absorbed a fear of birth
- are not familiar with current research
- don't believe research (in a leaflet about options for birth, our local GP practice states that the GPs believe hospital is safer)
- women often don't want to challenge their GPs, or assume that the GP must be right, or worry that other practitioners will be equally negative. They don't want to spend their pregnancies arguing with these people.

Negotiating home birth with midwives

We need midwives to be the first point of contact and we need to create a climate where that first contact is supportive. Women and midwives report a mixed scene across the country. One midwife told me that while she encourages women to think about where they'd like to have their babies, eight of her nine community midwifery colleagues don't want to do home births. This builds in conflict which is damaging for women and midwives.

Responses from midwives have a huge impact on women, because many are already anxious about doing something unusual. They might already have had negative responses from partners and GPs, so they are relieved and reassured when midwives are enthusiastic, and devastated when the response is negative:

'I contacted the midwives and one of them came out to see me [...] That was my first very disappointing experience. I was very disappointed because prior to that I hadn't expected much. I hadn't expected much from

my GP, but I thought, right this is one of the community midwives. This is someone who could deliver my baby. These are the people that I need to speak to. This is my lifeline and I knew from books that I was likely to be dissuaded, as it was my first baby. And actually that's exactly what she did.'

Of course, midwives too struggle with lack of resources, staff shortages, and mixed messages from colleagues and employers. They often find themselves on a tightrope: trying to balance work and life, coping with varying degrees of knowledge, skills and confidence, challenging restrictive policies without attracting too much hostility, and managing complicated relationships with employers and colleagues. These complexities spill over onto the women in their care in all sorts of negative ways. They might be told by midwives that:

- being on call is difficult to juggle with family life
- home birth is fine, but not in their particular circumstances
- women don't have home births here - so they have lost confidence
- they have two home births that month and are fully booked
- they are short staffed because of illness, maternity leave and cutbacks - this has created a new set of negotiations about whether or not there will be a midwife available on the day.

We can appreciate all these reasons - the pressures are crushing,[1] but it's completely counterproductive for women who want support, and who don't want to be battling with this dense thicket of hostility, evasion and non-engagement.

Part of the difficulty is to do with the Government's two handed approach - one very visible hand orchestrating calls for home birth, and the other more hidden one, busily dismantling NHS resources, and then blaming local services for not implementing Government directives.

Negotiating risk

Negotiating risk is an integral part of planning a home birth, but is far from straight forward. There's a whole host of complexities around risk that might arise[2] One of the very confusing ones is the paradox between the potent obstetric perspective that home birth is risky, and its own evidence disputing this. There are numerous paradoxes within medicine. For example, routine continuous electronic fetal heart monitoring has no benefits and adversely affects outcomes. Yet:

'I'd still rather have somebody on a monitor than not, that's just more for my peace of mind. I know that fetal heart monitoring hasn't really changed the outcome of deliveries' [3]

These beliefs are difficult to negotiate because they are illogical, entrenched beliefs. The more women's views challenge obstetric definitions of risk, the more they have to negotiate. There is the unspoken 'contract' to negotiate - 'we'll book you for a home birth as long as you agree to transfer to hospital if we say so.' It might not be put so starkly, but the more a woman rejects a medicalised view of birth, the more negotiating there is to do. So both practitioners and women become anxious - midwives worr y that women will stay at home regardless and women worry that midwives will transfer them to hospital

regardless:

'they [midwives] would try and get me to assure them that if something was going wrong, that I would go into hospital, that I wouldn't be saying no, no, I have to be at home'

Does home birth guarantee control?

Having planned a home birth, it is usually assumed that while women have less control in hospital, they are in complete control at home:

'it is this external sense of control which is most likely to be experienced as lost immediately a woman enters the hospital institution. Hence, for some women maintaining control may mean having their babies at home.[3]

'The social relationships between the childbearing woman and her carers are different when the birth occurs in the woman's home, where she is in control and her carers are guests.'[4]

'...they own the whole shop and can be in charge of the whole enterprise.'[5]

Certainly, among the machines, the busy-ness and the sheer numbers of people in a large hospital, practitioners tend to fall back on protocols and policies, and women find it more difficult to question these and may feel an acute sense of lack of control.

However, women say things are rather more complex. They question the assumptions about control at home and question whether control is the issue. 'Control' along with 'choice' arises from a consumerist model. Women and midwives say birth lies outside this restricted view: it is a journey; a rite of passage during which women need supportive birth companions working within a supportive birth environment, and that it's much more about feeling safe to let go than about control.[6]

Negotiating normal birth

Is home birth synonymous with normal birth?

Women say this is complicated too, because different perspectives on birth, different midwives and different women define normal birth in different ways. Women planning home births often define normal birth in terms of undisturbed birth. While women (and midwives) assume that home birth practices are more closely aligned with a social, midwifery model, midwifery practices are usually influenced by medical policies and practices, at least to some extent.

Negotiating different views and practices

As women think about birth and its possibilities, they often begin to see that some obstetric beliefs and practices are being brought into their homes. Some are so taken-for-granted that women don't get to know about them, and midwives don't realise that they are imposing practices, or that alternatives exist. For example, women do not necessarily know syntometrine is often used for the birth of the placenta or

that midwives might use their hands on the baby's head to 'assist', as the baby is being born:

'it is difficult because there's so many layers that you've got to get through. You've got to tell them that you don't want syntometrine or whatever - you've got to know all these things that they're going to do just as a matter of routine...if I would have guessed that she was going to hold the baby's head as it was coming out, I would have put that in my birth plan, to say, no, I don't want that'

In any given time and culture, there may be contentious birth practices. Currently for example, many women and midwives consider active management of second stage, the use of syntometrine, restricting time 'allowed' for the birth of the placenta, and the use of vitamin K, to be accepted practices rather than medical interventions. But for women who want undisturbed births, these interventions may be unwanted as long as no specific medical complications arise.

To add to the confusion, midwives' policies might be to give syntometrine and vitamin K for example, but some midwifery teams may be more relaxed about these than others in the same area. Individual midwives in the same team might have differing views about these, and some midwives might be relaxed about one routine practice, but may have strong feelings about another.

It's almost impossible for women to find out about and successfully negotiate undisturbed birth antenatally because there might be 15 or more midwives in their team, none of whom have time for detailed discussion and many of whom will feel anxious if women question local or individual practices. If women can't be persuaded to accept those antenatally, they might suggest 'waiting and seeing' - which makes women anxious because they know they'll be vulnerable during labour and likely to agree with suggestions.

Negotiating established, taken-for-granted practices

There is another layer of negotiations about practices that are even more difficult to question. As women think about giving birth and about being undisturbed, some begin to question established practices such as monitoring the baby's heartbeat and/or vaginal examinations.

From an undisturbed perspective they begin to think - if some interventions are unnecessary, are any interventions necessary and what is the impact of these interventions?

'if she'd examined me, I could really picture myself just getting closed up, thinking of someone touching me inside'

'I was assured that they would only do them [VEs] out of necessity, but I still don't understand why they're necessary. I have the feeling that they can't observe women and feel that things are alright without having to use physical monitors all the time. That is what I find slows me down, interferes with me'

They begin to question the necessity and impact of any practice that potentially disturbs labour and birth. The trouble is, often this is in the context of mistrust. The following quotation shows how a combination of conflicting ideologies and lack of trust has a devastating impact on how women and midwives relate, how at odds they are and on how unsafe they feel:

'when I decided to actually get the pool I think there was a feeling of liberation. I could run away from the midwives into the pool. For the first time I thought I could take a bit of personal power and that that would give me confidence. I could remove myself physically and have something to get into which they weren't going to follow me into'

But:

'the next visit, one said to me very proudly that they had a sonicaid that worked under water and my heart sunk. I thought, oh, they're going to chase me in the pool. And then they said they would want to measure my blood pressure and the temperature of the pool and all these sorts of things, and I thought, here comes the control issue again'

Safety

Relationships and holistic views about birth.

The difficulties women describe are usually transformed when they are cared for by known and trusted midwives who share their more holistic view of birth. It's this trust and broadly shared perspective that gets rid of all the extraneous negotiations that take valuable time and energy, and that make women and midwives anxious, more rigid in their views, and lead to the kind of damaging conflict that makes for unsafe situations. The difference is vast:

'I really trust her and I trust her judgement you know, and, I know when I go into labour and she'll come and she'll check everything and if she says everything's okay I'll believe her, I'll trust her that it is okay. But if you had a midwife that you couldn't communicate with and you didn't feel comfortable with, the whole thing just wouldn't work. I think it is really important to have a relationship with your midwife.'

'the difference of just knowing I'd have someone more in line with my thinking, I didn't feel that I needed a birth plan any more. I don't need all these things because I trust her opinion and that way I don't have any fears.'

Importantly, apparently unwanted 'checks' look different in the context of a relationship:

'the difference is because I have time to get to know my midwife. So what normally happens is that she comes round, we have a cup of tea, we have a chat, then by the time she's been there for 45 minutes or an hour, we do the check. So she will do all these things, but it seems relevant. It's like somebody you know who's caring for you, checking that you're okay, so it feels different.'

Trusting relationships free women and midwives to respond mindfully to each individual birth, so that

midwives can support undisturbed birth and gain more skills and confidence, and so that women trust that if midwives suggest transferring to hospital, that this is the best thing to do, that if they suggest a vaginal examination it is to provide specific information, so that they can use their midwifery skills to turn a baby or help the woman adopt different positions, and that if they ask to listen to the baby's heartbeat frequently, it is because they suspect a problem.

Skills

Trusting relationships come not only from knowing midwives, but knowing that they are skilled. From their experiences, women say that midwives need 'more skills', especially 'low-tech' skills of the body to help them give birth safely and straightforwardly, and to help them when birth is not so straightforward - before resorting to invasive interventions. They need midwives to know about birth intimately - emotionally as well as physiologically - to know about how to work with women's fears and struggles that might get in the way of normal birth. They need midwives who have the confidence to be with women in labour, inspire them and be courageous when they lose hear t and want to give up.

Women say what we know already - that both trusting relationships and positive birth culture need to be in place for women and midwives to be able to have better experiences without all the unhelpful negotiations that compromise their safety and well-being.

Where now?

It is difficult for midwifery knowledge and skills to develop within technocratic institutions, where technical medical skills are highly valued and over-used. We know that these environments are driving midwives away and that women don't like them. The task now is to build on sustainable models that: foster relationships, enable midwives to develop their skills, work for them and avoid stress and burn out.

Home birth and Birth Centres provide these models. They change the emphasis from technology to relationships and less invasive skills. If we only look at the Albany Midwifery Practice, Mavis Kirkham's book on Birth Centres, Denis Walsh's work, the Montrose Birth Centre in Scotland and work by Chris McCourt and Trudy Stevens - that would be compelling enough, because they clearly offer protection to women, babies, families and midwives in numbers of ways. They:

- reduce damaging, extraneous negotiations
- protect safe bir th for families and midwives
- reduce stress for families and midwives
- enable midwives to gain the knowledge and skills they need to support women
- enable women to protect their babies, themselves and their families from unnecessary physical, emotional and spiritual harm
- protect well-being and set parents up for parenthood and life
- potentially heal past wounds and avoid new traumas during a heightened state of awareness, that will have considerable impact - perhaps ongoing over a lifetime.

As the evidence gathers it points ever more authoritatively to midwife-led caseloading care in community settings being the best care available for healthy women and babies.

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