AIMS For a better birth...

What is Normal Birth?

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Time to stop confusing what is common with what is normal

In an issue devoted to the problems of attaining a normal birth, Beverley Lawrence Beech outlines some of the things that can go wrong and some reasons why they continue to go wrong.

The majority of fit and healthy women invariably expect to have a 'normal' birth. In an attempt to understand what will happen to them during birth they devour childbirth magazines, women's magazines, health education leaflets and any other material they can find. Believing that the experts know best they happily follow the doctors' and midwives' advice in the expectation that they will be safe in the hands of professionals, and their birth plans, if they have made them, will be respected.

As time passes some may have an inkling that there is something they have not been told, though they can't quite put their finger on what it is. A state of panic begins to creep over them and many will approach birth with some trepidation, if not alarm. Yet they continue to hope that in their case they will not be the one to get the caesarean, forceps or ventouse delivery. This cycle of blind faith, suspicion, alarm and panic is now a normal part of the emotional terrain of modern birth.

In 1997 AIMS raised the question of what is normal birth? So often women tell us of their traumatic birth experiences and state that they are not going to have a 'normal birth' next time - they want to have an epidural right away; or book an elective caesarean the next time. So often when we point out that they did not have a normal birth last time such women are amazed. Unfortunately, if the baby is born vaginally (without forceps or ventouse) the midwife invariably writes 'normal delivery' on the case notes. The women then presume that the high-technology interventive, obstetric delivery they endured was 'normal'. Common or usual it may be, but normal it certainly was not.

Because of this AIMS made a plea for someone, somewhere to conduct a study to find out just how many women in the UK had 'normal' births. Soo Downe, research midwife at Derby City Hospital and Carol McConnick, labour ward manager at Nottingham City Hospital accepted the challenge and embarked, with AIMS, on a study of five consultant units in one region to investigate.

For the purposes of the study women who did not have induction or acceleration of labour, artificial rupture of membranes, a caesarean section, general anaesthesia, forceps and/or ventouse, epidural anaesthesia or an episiotomy were classified as having 'spontaneous vaginal births'. The results summarised on page 4 are worrying: only one in six first time mothers fell into this category and one in

three for those who had given birth before.

The study also revealed that only a quarter of the women classified in the hospital statistics as having a normal delivery actually had a spontaneous labour and birth. Electronic fetal monitoring was not included in the study because of the huge variations in how long it is used in labour. Had it been included, we wonder just how few women would be left?

The implications of these findings are serious. The majority of midwives learn midwifery in large centralised obstetric units. Those units deskill midwives and turn many of them into machine-watching obstetric nurses. Last year we heard from a midwife who was nearing qualification who expressed her concern that in the last two years she had not seen one normal birth - practically every woman in her hospital had epidurals or other interventions. How can a midwife in that environment understand how a woman behaves in normal labour? How can she understand the importance of support and encouragement when the majority of women may be wired up to a drug-dispensing drip?

At a recent conference organised by the Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives and the National Childbirth Trust (see Reports, 'From Audit to Action' page 19) the most dramatic presentation came from Keith Greene, a consultant obstetrician, and his midwifery colleague, Mo Harris, who showed excepts from their video recordings of activities in a labour ward.

The video revealed that communication with the labouring mother was practically non-existent. Midwives would enter the room, barely look at the mother, turn their backs on her and pay attention to the notes. Staff changes and handovers excluded the woman who was stranded on a bed, on her back, and even her partner ended up not involved but slumped in a chair.

The video graphically demonstrated the brutalising effects of hospitalised birth. It showed that one-to-one midwifery care does not equate to continuous support. This video clearly showed the lack of midwifery support for a labouring woman. No wonder many women are demanding home births.

However, having booked a home birth there is no guarantee that the woman will get a midwife who is either experienced or enthusiastic about the process. AIMS' experience is that during labour such midwives often find spurious excuses to persuade women to agree to a transfer to hospital - a place where the midwife feels much more at home. Janette McCabe's experience (see page 5) is just such a case.

On the pretext of 'high' blood pressure her midwife transferred her to the Simpsons Memorial Hospital in Edinburgh during the labour. Janette's story is a classic example of how to convert an otherwise normal labour into a high-tech nightmare. Her birth plan was ignored. She was assaulted during the labour by the specialist registrar who ignored her instructions to stop when she conducted a very painful internal examination. She was used to teach another doctor how to do a forceps delivery (without her consent). She was also used as an 'interesting case' by the numerous people who felt they had the right to invade the room to watch (including one man whom the hospital still cannot identify).

Her complaint was not resolved because the issues she raised were not adequately addressed. For example, hospital staff considered that although her birth plan had explicitly said she did not want any students to attend her, as the doctor was a trainee her wishes were considered not to be applicable.

We know that there are midwives in the Simpsons who are desperately trying to give good quality midwifery care, but while the unit is so grossly under- resourced and the importance of continual midwifery support not acknowledged, is it any wonder that the Simpsons has such high caesarean section and operative delivery rates?

So many midwives need to relearn midwifery skills and gain confidence in their ability to facilitate a normal birth process. But they will only do so when the services support case-load community-based midwifery backed up by small midwifery run units. With the majority of women birthing in such units, or at home, the centralised obstetric units can then he used appropriately to manage the minority of high-risk women and babies who need those skills. Without such sweeping changes in the status quo of birth the National Health Service has a difficult problem to address: how to teach and maintain midwifery skills so that midwives fulfil their primary function - to protect and facilitate the normal process of birth. Only then can AIMS expect to receive fewer examples of the sub-standard and inappropriate treatment Janette received.

References

1. Beech BAL, Normal birth - does it exist? AIMS Journal 1997: 9(2): 4-8.