AIMS For a better birth...

# Normal Birth - Does it Exist?

**Normal birth is something to which the majority of expectant women aspire. Many women attend antenatal classes to prepare them for normal birth, and most British hospitals claim a normal birth rate in excess of 70%.**

But what is normal birth? The World Health Organisation in their latest publication CARE IN NORMAL BIRTH: A PRACTICAL GUIDE states that normal birth is "*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 of pregnancy. After birth mother and infant are in good condition.*"

Excellent, but it does not go far enough? The definition will cover the woman who arrives in the labour ward, whose labour is perceived not to be progressing fast enough, who has her waters broken, an oxytocic drip set up, or a prostaglandin pessary inserted, continuous electronic fetal monitoring, an epidural (because by this time the pain is excruciating) and, when it comes to the birth, she has an episiotomy.

The hospitalisation of childbirth has resulted in a volley of interventions and a failure to recognise the effects medicalised birth has on the process. As WHO has said: *"By medicalizing birth, : i.e. separating a woman from her own environment and surrounding her with strange people using strange machines to do strange things to ber in an effort to assist her (and some of this may occasionally be necessary), the woman's state of mind and body is so altered that her ways of carrying through this intimate act must also be altered and the state of the baby born must equally be altered. The result is that it is no longer possible to know what births would have been like before these manipulations. Most health care providers no longer know what "non-medicalized" birth is. This is an overwhelmingly important issue. Almost all women in most developed countries give birth in hospital, leaving the providers of the birth services with no genuine yardstick against which to measure their care. What is the range of length of safe labour? What is the true (ie absolute minimum) incidence of respiratory distress syndrome of newborn babies? What is the incidence of tears of the tissues surrounding the vaginal opening if the tissues are not first cut? What is the incidence of depression in women after "non-medicalized birth? The answer to these, and many more questions, is the same: no one knows. The entire modern obstetric and neonatological literature is essentially based on observations of medicalized birth" (WHO, 1985)*

While CARE IN NORMAL BIRTH states that: "*in normal birth there should be a valid reason to interfere with the natural process*" it goes on to define the tasks of the caregiver "*...performing minor interventions, if necessary, such as amniotomy and episiotomy*". We do not consider amniotomy or episiotomy to be "minor" interventions. Amniotomy can have a devastating effect on the progress of labour and episiotomy can have equally damaging effects postnatally. One of AIMS current concerns is the number of cases we have had of midwives undertaking amniotomy at home and creating dangerous problems, some of which

resulted in a dead or damaged baby. It appears that some Trusts have failed properly to re-skill midwives for home births and have left them to conduct a hospital delivery at home. In hospital, when an unnecessary intervention leads to problems there is a friendly obstetrician down the corridor to rescue the mother and baby. If it happens at home the midwife can find herself many miles away from help. Too many midwives are expected to manage a home birth without adequate support or adequate re-education. Because many of them have never seen a normal birth they are woefully ignorant of the implications of routine hospital procedures misused at home.

## Losing sight of normal birth

The perversion of normal birth is so widespread many midwives have lost sight of what a normal birth is. How often do they see it? Indeed, in many hospitals, if the baby is delivered without a caesarean section, ventouse or forceps, the staff perceive the women to have had a normal birth.

So insidious has been the erosion of our perceptions of normal birth that the new President of the Royal College of *Midwives, at the RCM's annual conference, suggested we distinguish between normal childbirth and natural childbirth. "Natural childbirth is allowing childbirth to proceed as nature intended - this means some will be successful, some will be damaged and some may die in the process - very much like they do in the Third World where, as I have said, a Jumbo-jet of women die in the attempt every day. Normal childbirth on the other hand is what you and I have been* trained to facilitate, and I would define it, as allowing childbirth to proceed with in agreed parameters of normality, there may be debate about who has set the parameters of normality, but parameters have to be set. Natural childbirth and normal childbirth may be very different things".

Laura Muirhead's perception, that natural childbirth means some dead and damaged women and babies, overlooks the effects of poverty, disease, inappropriate interventions and rituals and, in this country, according to the latest Confidential Enquiries into Maternal Death, sub-standard care - which was identified in almost 50% of the maternal deaths in the UK (and probably elsewhere in the world too).

The World Health Organisation also makes a distinction between normal and natural and states: "In normal birth there should be a valid reason to interfere with the natural process. The problem in this country is that midwives like Laura Muirhead, a labour ward sister for almost 30 years, meddle in the natural progression of labour so much they have lost sight of what a normal birth is. Our files bulge with reports from women who perceive their birth to have been a nightmare from the time they stepped inside a hospital. Yet, often when the case notes are examined these women have been subjected to the standard meddling that is endemic in our hospitals, with no indication for the interventions in the first place - and "normal delivery" is entered on the notes.

When campaigning for support for normal birth, informed consumers are not suggesting a "get on with it no matter what" policy, some women need help, but it should be appropriate help, and it should be given when needed. It should be recognised that while this help may be appropriate in a specific labour its routine *application can, and does, cause considerable damage to both mother and baby. For millions of years women have been producing babies. We are the most successful species of all, but our success as a species has led to the unrealistic expectation that every pregnancy should end with a fit and healthy baby, no matter what, and obstetricians have encouraged that expectation in order to justify the unacceptably high levels of*

*intervention and constraints imposed by these* experts in abnormality.

## Changing childbirth?

In 1992 the House of Commons Select Committee published its report on the maternity services (the WINTERTON REPORT). By gathering information from consumers as well as professionals and travelling around the country and interviewing women in a variety of settings, they realised the implications of the high levels of obstetric management. At a meeting in the House of Commons, Jean Robinson remarked to Audrey Wise MP (one of the Committee members and the person who persuaded the MPs to conduct the enquiry) how remarkable it was that a predominantly male committee were astute enough to understand the effects of technological births. Audrey replied that it was not remarkable at all. When they visited large maternity units the women they spoke to were pleased they had got a baby and very "relieved"; but when they visited women in small units, the women were absolutely bubbling over with delight. Jean then asked if Audrey meant that the men had - noticed something as subtle as the differences in the women's behaviour. Audrey replied, "*Oh, Jean, it wasn't subtle. The difference was so noticeable it hit them between the eyes*"

When the Government accepted the WINTERTON REPORT and launched its Changing Childbirth programme we

jumped for joy. At last, women would get the care they needed and the normality of birth was recognised and would be supported.

Five years on, the Changing Childbirth Team is being run down. The bodies of enthusiastic, worn out and disillusioned midwives scatter the country, and Trusts, having funded a myriad of pilot schemes, are now telling the midwives that even though the schemes produced better outcomes, healthier mothers and babies and more satisfied women, and, where they had been set up properly, more satisfied midwives, there was no money to fund their continuation.

The drive to centralise maternity care in large maternity units continues, but no-one has sought to save money by dealing with the over provision of consultant obstetricians, the huge costs of technological births, and the overpayment of fees to GPs who meddle in maternity care but do not provide an adequate service.

We had hoped that the Royal College of Midwives, under the Presidency of Caroline Flint, would vigorously promote midwifery care and change the face of maternity provision in this country. Instead, certain individuals within college ensured that Caroline did not stand for a second term as President and elected one of their own back-woods-women to replace her.

The changes we achieved in persuading Government of the need for a form of care which facilitated normal birth were gained because consumers and midwives worked together. We had a common aim, and we were successful in achieving it. That achievement is now threatened by a Royal College which appears to hanker after the role of handmaiden and whose new President has lost sight of what normal

birth is.

## The influence of the press

A childbirth magazine recently published the stories of the birth experiences of three women who had their babies in the 1942, 1957, 1978 and 1994. The difference between them was that the woman who gave birth in the 1940s had a normal birth at home, and described it as a wonderful experience; the woman who gave birth in 1957 stated that "The whole business was a nightmare" and the woman who gave birth in 1978 "felt like a processed pea". The woman who gave birth in 1994 had almost exactly the same obstetric meddling as the previous two hospitalised women but claimed she "couldn't have been treated better". The magazine made no comment about the medicalization of birth and the inappropriateness of the procedures to which these hospitalised women had been subjected.

None of this country's childbirth magazines honestly inform women of the reality of giving birth in large centralised obstetric units. The focus is on "choice" and as long as the woman has chosen, that's fine. No comment is ever made about the appropriateness of their experiences. This focus on choice, often without real knowledge, is leading women to "choose" a caesarean section, choose an epidural, or choose a normal birth unaware that they are choosing hospitals where they have as much chance of getting a normal birth as they would of finding snow on the moon.

The majority of journalists writing about childbirth issues are women. Almost to a woman, they are wedded to the idea of birth in hospital with the choice of a wide range of drugs, and any other intervention, on the grounds that they are entitled to make the choice and the sooner they get back to their desks the better. They are women who have made an impact in a man's world and have accepted and adopted masculine ideals wholeheartedly. Most of them have done nothing to investigate normal childbirth, and such is their fervent belief in technology they, like any religious zealot, dismiss any negative information.

Unfortunately, such is the isolation of childbirth in our country few women get the chance of seeing a normal birth. What's more since in their eyes normal birth lacks the trauma, the human tragedy, in short a "hook" to hang a story on, our journalists can't see the point of publicising it. There is also a question of expertise. How is it that Rosie Millard, an arts correspondent at the BBC, whose knowledge of childbirth issues extends as far as her first (high-tech) pregnancy, can get an article published in the INDEPENDENT, but Pat Thomas who has written two key books on childbirth EVERY WOMAN'S BIRTH RIGHTS and EVERY BIRTH IS DIFFERENT, cannot get a despite her work being described as "*A marvellous antidote to the misinformed pap served up by most pregnancy and birth manuals*"? This isn't just sour grapes - it's an important point with implications for the health of mothers and babies throughout the country.

In her INDEPENDENT article (16 June 1997) *Epidurals: to have or have not?* Ms Millard, in a determined effort to ignore the risks of epidural anaesthesia, disparages women who want a normal birth "*..I have discovered that those who chose to go it alone tend to expiate their hours of agony in the delivery suite by climbing up on to a pedestal and making everyone else feel completely lily-livered afterwards. Having a "natural" birth has become a sort of postnatal brownie point in martyrdom*

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It appears to be an almost impossible task to explain to career women journalists that many women want to avoid drugs and routine hospital meddling in labour because they are well informed and understand that where the conditions which facilitate a normal birth are in place (i.e. companions you trust, in a a place in which you feel safe, with birth attendants who are skilled at facilitating normal birth), you stand a greater chance of giving birth normally. The pay off is that your baby will be fit and healthy at the end of it, and just as important - So will you.

Unfortunately, many women who want a normal birth fail to understand that their chances of getting it in the majority of our maternity units is remote.

Normal birth is not continuous agony from beginning to end, but if you have gone into a large maternity unit had your waters broken, a drip set up and continuous electronic fetal monitoring it is very likely to be agonising, and it can be continuous agony. Driving a uterus with oxytocin is very painful, and very few women manage to get through theirlabours without pain relief. What women fail to understand, and the press will not tell them, is that epidural anaesthesia gives, in most cases, complete pain relief, but it also enables the staff to drive the uterus at far higher levels than are physiologically possible. The added pain of this is masked by the epidural.

No-one has researched the added stress and pain to the baby of ramming it through the pelvis with oxytocic drugs; although one can surmise that the increase in caesarean sections is a reflection of the damage this management does to the baby. Fortunately, most babies are extremely tough and they appear to recover within a few days. In the mean time the mother may be struggling to feed a drugged baby or trying to comfort an unsettled, crying, baby which may be suffering from a severe headache. Cranial osteopaths are finding more and more work realigning misplaced cranial bones as a result of medical mismanagement.

## The effects of drugs

Women who want a normal birth are often denigrated as being selfish - as if they are only thinking of themselves not their baby. The critics fail to recognise that routine obstetric interventions carry risks. The risk of the labour becoming much more painful and inco-ordinate, the risk of needing drugs to deal with the increased pain; and for the baby there is the risk of the long-term effects of drugs - much of which are unevaluated.

It is, however, just as damaging to mother and baby to attempt to give birth in persistent severe pain as it is to sign up for all the routine interventions so common in our maternity units. There are women who will need drugs and medical intervention, and no one would deny them appropriate pain relief; but there is a difference between getting these drugs because one needs them and getting them because of successful marketing ploys or routine provision.

While many women will avoid smoking, drinking or taking over-the-counter drugs because they are

concerned about their baby's well-being, the moment they step inside a hospital this caution is abandoned and they are more than happy to sign up for an epidural, accept oxytocin or prostaglandins, or, if they live in Scotland - diamorphine (heroin). These drugs are far more powerful than the over-the-counter drugs or cigarettes, or the odd glass of wine, but because the drug pushers are midwives and doctors the women accept it. In contrast, those women who are concerned not to use drugs during labour often meet with antipathy and an attitude of "she'll soon be begging for it". Ironically, if she has chosen to give birth in a unit which has high intervention rats, and a policy of active management, the midwives will probably be right.

Caesarean operation rates

Obstetricians, in justification of the appalling caesarean section rates, are now claiming that this is because women are asking for caesareans. Some women are, but they do so, in the main, from a position of fear and ignorance. The last request I had from a women who wanted to book a caesarean section was provoked because she had five friends who had all given birth in the last six months. None of them had a normal birth, although all allegedly had expected one.

All the women had actively managed labours with the usual catalogue of unnecessary interventions resulting in two emergency caesarean sections and three forceps deliveries. They had given graphically horrendous descriptions of their labours. It was hardly surprising that their friend was desperately anxious, and wanted to avoid such trauma and book a caesarean.

Informed consumers are not suggesting that every woman will have a normal birth, some women will need assistance, and their birth experience can be still be as fulfilling and positive (and beneficial to the baby). But, not many women achieve what we would consider a normal birth, and those that do should not have to fight to achieve it.

## Defining normal birth

While hospitals persist in describing a baby who arrives vaginally without forceps or ventouse as "normal delivery" women will continue to be misinformed about normal birth, and prevented from accurately assessing the chances of achieving a normal birth in hospital.

To address this problem AIMS has written to the National Maternity Record Project and the Department of Health:

*"Parents need to know about outcomes in order to choose the type of care they want. At present statistics of '* normal delivery*' are gathered and hospitals regularly quote their normal delivery rates. This is a medical term which refers to the birth of a baby vaginally, without recource to forceps or ventouse."*

*When parents talk about* 'normal birth' *or* normal delivery' *they mean a physiological birth where the baby is delivered vaginally following a labour which has not been altered by technological interventions. It does not, therefore, refer to a vaginal birth where the mothers have had artificial rupture of membranes, induction or acceleration by drugs, and.intravenous glucose drip, epidural anaesthesia or episiotomy".*

Many woman who give birth vaginally after such interventions think of their birth as "normal", and this categorisation by hospitals is misleading. We believe that the normal delivery statistics should be re-defined as Normal Birth or Technological Birth.

Most case notes contain a computerised Maternal Summary. We suggest it should contain a further section:

Artificial Rupture of Membranes YES/NO
Induction of labour YES/NO
Acceleration of labour YES/NO
Epidural anaesthesia YES/NO
Episiotomy YES/NO
(Note: if the response to any of the above is YES, then the birth should be recorded as a technological one).

Type of delivery:
Normal birth YES/NO
Technological birth YES/NO

By this means perhaps we will be able to impress upon both midwives and mothers the difference between a normal labour and the actively managed technological births experienced by the majority of women in UK hospitals.

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## References

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