AIMS For a better birth...

Perspectives on normal birth

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Written in 1996, Californian midwife Ronnie Falcão's description of what goes wrong in modern birth and the importance of the choice of caregiver is as valid as ever.

I recently returned from a three-month internship at one of the birthing centres that doubles as a training centre for direct-entry midwives. I had already studied a basic course in midwifery academics, and had apprenticed briefly as a labour coach and midwife assistant, but it was clear that hands-on experience would come very slowly. The requirements for both national certification as a Certified Professional Midwife and licensure in California include at least 20 births where I act as primary attendant under supervision - which could take years as a standard homebirth apprentice.

Because I'm already nearly 40 years old, I selected an intensive midwifery training programme that offered the experience I needed, although there were sacrifices in terms of tuition money, rigorous conditions and three months spent away from home.

Fortunately, my sacrifices were amply rewarded with an amazing amount of valuable education and experience, including a new perspective on how outrageously unnecessary caesarean rates of 20-30 per cent are. During my three months at a birthing centre, of 116 labouring women, only one ended with a caesarean - a rate of less than 1 per cent.

I've given a lot of thought as to why this rate was so low. Despite the at- risk population many of the clientèle struggled to afford the low birth fees and the recommended supplements - they managed to grow healthy babies nonetheless. A number of the women had android or platypelloid pelves not ideally suited to giving birth. A lot of the 'young women' were girls, many under 18. And, as in any population, there were women with family situations or past traumas that made giving birth a trying, emotional ordeal-with episiotomy or caesarean scars, VBACs, PIH or polyhydramnios; there were first-time moms, even one breech birth.

So, how could this birthing centre have such an excellent success rate, and all with no drugs for pain relief, no electronic fetal monitoring and no intravenous Pitocin? Well, that's probably half the answer right there. Recent studies have shown that active management (Pitocin augmentation) and continuous electronic fetal monitoring do not improve outcomes for moms and babies; in fact, they only seem to increase the caesarean rate. So maybe the 'shortcomings' of an out-of-hospital birth were part of the secret to success.

Or perhaps it was the built-in doula system. Although most labouring women did not have continuous

labour support from birthing centre staff, they were individually observed each 15 minutes or so when the responsible intern checked the baby's heart rate. Each visit was an opportunity to note the mother's condition, progress and contractions. We did a lot of the standard doula work-recommending changes in position, making sure they were eating and drinking enough to keep up their strength, suggesting a shower at a transition point. Sometimes, for a mom without a family to support her, we would stay with her if she was having a hard time. But most of them had family staying with them.

So, could the labour support have made the difference? Maybe, although doula studies only show a 50 per cent reduction in caesareans.

So, I kept thinking. And then it came to me. These women were getting the kind of care that money can't buy. Each of these labouring women had a dedicated caregiver who had or knew how to access the necessary expertise to help each woman have a vaginal delivery - and each caregiver desperately wanted the labour to end in a vaginal delivery.

I'd like to say that our dedication was because of our unrelenting support of natural childbirth or to the clients. But, in reality, working every day of the week, 75 hours/week, sometimes with clients we'd never met before, our motivation was not entirely pure. We needed the birth to be a normal, spontaneous vaginal delivery and to be as easy as possible for the mom so she would progress well and give birth on our shift, or else it would count as a catch for some intern.

Averaging out the tuition money and time spent at the birthing centre, each baby I caught cost me over $100 and half a week away from home. But truly, I wasn't thinking of all the economics. I only knew that I had waited for nine long months for the opportunity to catch babies, and I wanted to catch as many as possible. I stayed for hours after my shift ended if it meant an opportunity to catch a baby that looked imminent, as was permitted by policy - even though I would then also be required to provide another couple of hours of postpartum care.

So basically, the labouring woman was in the care of someone who happened to have an unusually strong commonality of interest - an efficient, easy, vaginal delivery.

It didn't always work out that way - there were first-time moms who needed one-on-one labour support for the better part of my 12-hour shift, and then didn't deliver until six hours into the next shift. I feel very lucky to have been at a place where I could still share in her triumph as we had the opportunity to observe every birth, even when not on our shift. (No, please don't ask when we slept; it makes my body wince to think about it.)

But mostly, my intense focus on keeping the woman's labour 'easy' and efficient was rewarded. I learned how to keep an eagle eye on heart rate, to notice the first little beginnings of a troublesome pattern and to keep trying things until we figured out what was causing it - almost always the position the woman was in. Sometimes we saw early decels that made me a little nervous, but then we knew that the baby was at the spine and it might be a rough road through. No problem. I learned a lot about taking advantage of the relative relationship between the baby's head and the mom's pelvis. I knew that it was almost certain that

the baby could fit through this pelvis - it was just a matter of figuring out how.

And, mostly, it just took a lot of time, patience and hard work. There were some marvellous teachers there, and I saw babies birthed in just about every position between upright and a full squat. And I learned how to reshape a pelvis by applying pressure to this bone or that at the critical moment to help the head get through.

I learned the beauty of real midwifery, being with the woman, advising but not controlling. I saw some amazing examples of women who knew exactly what her body needed to do to get her baby out. Sometimes I would suggest a particular change of position, and she would start to assume that position, but somehow ended up in another position that I could never have imagined. Then, 15 minutes later, she was ready to push the baby out. I learned to have a profound respect for instinct.

I learned to take pleasure and pride in minimising the interventions, trying instead to help the mom deliver nice and slowly, assuming that the baby's heart rate wasn't worrisome, The slower the better: the baby was better oxygenated at birth, and the moms didn't tear. The rate of tears that needed suturing was about 15 per cent while I was there, even with the small mothers and big babies. I saw nine and 10-pound babies born with no tearing.

So, will I be able to duplicate this level of success in my own midwifery practice? Sad to say, probably not. I'll probably need to transfer care earlier for women with borderline conditions, mostly due to legal restrictions. I personally won't do breech births until I have a lot more experience, but I do know an excellent homebirth midwife who is more than qualified to attend breech or twin births. And I'll probably never feel the same passion about really, really wanting the woman to deliver under my care. This is probably a good thing and will keep me from making decisions that might not be appropriate for a homebirth even when they are appropriate for the birthing centre, where there are lots of experienced hands around.

However, I will strive with every ounce of ingenuity to see that I match the overall statistics. I will hope to be able to say that, of all the women who entered my care, less than 1 per cent had caesareans, even though my transport rate may be more like 10 per cent.

I hear myself saying this and I hear the voices of doubt saying, "But even Marsden Wagner says that caesarean rates less than 5 per cent tip the balance towards losing moms and babies unnecessarily."

But I know that this is only the case when you're getting care that money can buy. That's the type of care that isn't passionate about preparing each and every mom mentally and physically for a vaginal birth. That's the type of care that doesn't even believe in the concept of setting a mom up for success through prenatal education, visualisation and appropriate herbs. That's the type of care that knows they can always do a caesarean. That's the type of care that doesn't give you much information on how to turn a breech baby other than to schedule an external version, knowing they can do a caesarean if things go wrong or it doesn't work. That's the type of care that thinks it's easier to have a mom with an epidural than a mom who's up and about, changing position, eating and drinking to meet her needs. That's the type

of care that ignores those early warning signals of a funky heart rate and ends up doing an 'emergency' caesarean for a situation that could have been prevented-but only by the kind of care that money cannot buy.

I feel confident in saying that if any given woman offered a skilled caregiver a million dollars to ensure she had a vaginal birth, that woman would have a vaginal birth 99 per cent of the time. Why? Because then it would be economically feasible to spend an hour with her at each prenatal visit, and address issues of presentation and position at every appointment. It would make economic sense to anticipate the physical/social/emotional/ psychological issues that might become a problem for this particular woman, and to advise strategies for coping with them. It would then make a lot of sense to facilitate the woman's going into labour at the first favourable opportunity-this can be easily achieved through herbs and relaxation/ visualisation, but is rarely done. It would also make infinite sense to visit the woman early in labour to make sure that the baby's position was favourable before it became too late to change it easily. It would then be extremely cost-effective to hire the best help necessary to provide non-pharmacological support during labour-such as massage, chiropractic, hypnotherapy, a birthing tub, a TENS unit-all in her own home, where she can labour most easily and effectively. It would then obviously make sense to attend the woman full-time once she was in active labour to make sure that everything continues to go well, and there would be no rush to hurry the pushing phase or the crowning, or the cutting of the cord or the bathing/separation of the baby.

In short, it would be a completely different experience - unfortunately, an experience that reasonable sums of money cannot buy.

But sometimes, that which cannot be had for money can be had for love. Love of the triumph of the human spirit in each birth, love of the strength of women as they labour to bring forth life, love of facilitating the easiest, gentlest, quietest birth possible. Love of life and love itself.

So, if you want to improve your odds of having a normal, spontaneous vaginal delivery and a triumphant birth experience, I recommend selecting a caregiver who does it for the love of the work above all else.

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