Successes and Challenges of Normalizing Birth in the US & UK

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Evidence supports that most women who are healthy upon entering parturition have the requisite capacity to birth their infants proficiently and with little intervention. However, maternity practices often do not reflect or draw upon the strengths of women's ability to birth, but focus on the potential risk. This is sometimes called the one percent doctrine where interventive surveillance techniques are applied to most women in hope of preventing problems for the small minority who will develop them. There is growing concern that these practices may be causing more harm than good, both short-term and long-term. Is it possible to reverse this trend? A recent Cochrane review of midwifery-led care supports a model of care that is markedly less interventive (Hatem, Sandall et al., 2008).

This presentation will draw from several studies that examine the influences of women's perceptions on pregnancy and birth and maternity practices in the United States and England. Kennedy (2000) studied expert midwives and women cared for by them to identify the most important qualities, processes, and outcomes of midwifery care. They identified that one of the most important qualities of a midwife is belief in the normalcy of pregnancy and birth. An important process of care was the critical art of doing "nothing" well. Finally, the critical outcome was optimal health of the mother and baby in the given situation. But what does it mean to have a "normal" or "optimal" birth and what does doing "nothing" mean? These areas of inquiry have been the focus of my program of research for the past 10 years.

Women are the most influential critical mass for change in maternity care and many use lay childbirth literature to gather information to guide them in decisions (Sakala & Corry, 2008). A recent discourse analysis of the top 10 selling U.S. childbirth books on Amazon.com revealed concerning media messages about birth, including body images, pain, the risk of labor, authority and autonomy, and cesarean section (Kennedy, Nardini, McLeod-Waldo, & Ennis, 2009). It is crucial that midwives and all maternity clinicians understand what women are reading as they prepare for birth.

As I explored normal birth (Kennedy & Shannon, 2004) and the concept of optimality (Kennedy, 2005) I began to collaborate with my United Kingdom colleagues who are doing considerable work in this area (NCT/RCM/RCOG, 2007). As a 2008 Fulbright Distinguished Scholar I conducted an ethnographic study at two NHS Trusts in London, known for their commitment to normalizing birth and decreasing their cesarean rates. We found that both trusts held an "ethos" of normality and specifically trained staff in techniques to support normal birth. Their clinical guidelines provided evidence-based strategies to normalize birth including the use of intermittent auscultation of fetal heart tones, one to one midwifery care in active labor, hydrotherapy and other low-interventive techniques for pain management, and nutrition in labor. They also were proactive in encouraging women to achieve a vaginal birth after cesarean. Many of their strategies are appropriate for other settings and some should be studied more in-depth, particularly in the interpretation of what strategies are safe or risky (Kennedy, Grant, Walton, Shaw-Battista, & Sandall, in press).

These findings were compared to a ethnographic study conducted in a similar setting in the United States (Kennedy & Lyndon, 2008). The nurses and midwives in this setting experienced tension about what constitutes safe care. During the conduct of the study the two professions participated in mediation meetings and eventually came to a level of understanding and commitment to working respectfully together – care practices changed as a result with enhanced communication and support of normal birth.

Future research should focus on participatory action methods that include all stakeholders in birth, including but not limited to midwives, obstetricians, nurses, pediatricians, neonatologists, administrators, risk managers, students, and most of all women and families. Only by conducting research that is relevant to the difficult questions we face in maternity care do we have a chance of understanding the complexities facing us, and developing evidence-based to strategies to address them.

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