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Margie Polden Memorial Lecture: The normalization of childbirth in modern maternity care

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Abstract

A straightforward healthy birth gives babies the best start in life, and offers mothers and fathers/other parents the ideal introduction to being part of a family. The physiological processes that maintain progress in labour and maternal recovery after birth, the health of the baby, mother–baby bonding, and breast-feeding are best supported when major interventions are avoided. This paper highlights emerging evidence about the physiological processes that occur during pregnancy, birth and the postnatal period. Cost-effectiveness is crucial, and higher rates of normal birth will ease the pressure on services and help to control costs. For women who require medical care, it is important that the experience is normalized as much as possible, and that support is provided during this critical transition to family life. Drawing on the Maternity Care Working Party definition of normal birth, the author describes the current rates of normal birth and interventions in the UK. She considers facts about the risks of intervention, and from evidence and experience, suggests ways of supporting normal physiological birth, including the establishment of supportive relationships, environments and practices, multi-professional working, and midwifery-led care and place of birth.

Keywords: maternity care, midwifery-led care, mother–baby attachment, normal birth.

Introduction

Thank you for the honour of being invited to deliver the Margie Polden Memorial Lecture. I knew Margie: we worked together when I was the Queen Charlotte's Professor of Midwifery Practice. I led a programme of developments in midwifery; in particular, the implementation of one-to-one midwifery practice, at Queen Charlotte's and Hammersmith Hospitals, London, UK. Margie and the physiotherapy department supported us in a number of ways, often attending our meetings, offering suggestions and helping, and there was a strong implicit understanding between us. The work of midwives overlaps with that of physiotherapists working in maternity care and women's health. Each of us brings extremely specialized knowledge and skill, but working closely together will enhance our contributions.

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My subject today is normal birth, and I want to focus for a moment on some examples of ways that physiotherapists have been helpful when I have been trying to support a woman so that she has the best chance of experiencing a normal birth. Take the woman who suffers from pelvic girdle pain or back pain, for instance. These are discouraging and tiring conditions that may edge her towards wanting an induction, and entering labour and birth already tired and distressed. Physiotherapy treatment and support, i.e. collaboration, can help considerably in such cases.

The Royal College of Midwives and the Association of Chartered Physiotherapists in Women's Health working together

The Royal College of Midwives (RCM) and the Association of Chartered Physiotherapists in Women's Health share the aim of supporting healthy birth, and ensuring that women are as healthy as possible after the birth of their babies. You may know that the RCM and the Chartered

Society of Physiotherapy have just issued a joint statement on pelvic floor muscle exercises (Gerrard & ten Hove 2013).

A good birth

It is of the utmost importance that women with straightforward pregnancies are given every chance of having a normal birth, while recognizing that, in some circumstances, women and babies have more complex needs and require medical intervention. A straightforward normal birth gives the mother, baby and family the best start in life, and appropriate support and an optimal place of birth will increase the chance of a normal delivery and help to avoid the risk of interventions.

Those women who have more complex needs may require medical care and interventions. Nevertheless, the aim of maternity care, no matter who provides it, is to support the mother, baby and father/other parent in their transition to family life, and give the child the best possible start. This is not only a matter of ensuring that the baby is physically healthy, but also of supporting the growth of the bond of love between the family, increasing confidence and competence, and ensuring that the experience of care is positive. Even when care is complicated, perhaps especially so in these cases, it is important to ensure that every woman is involved in making decisions together with her professional caregivers, and that her beliefs, values and preferences, as well as her medical history, state of health and current best evidence are taken into account. What has been referred to as woman-centred care involves making sure that the mother and her baby are placed at the centre of care, and that their needs and wishes are paramount.

Physiological processes should be supported as much as possible, even for those women who need medical care and interventions. It is always important to remember that the birth of the baby is also the birth of the mother, and the quality and experience of the maternity care that the woman receives will affect both her ability to look after her baby and her experience, particularly that of the start of family life.

What is normal birth?

The definition of normal birth was agreed by the Maternity Care Working Party, which issued a statement that was endorsed by its members, including the RCM, the Royal College of Obstetricians and Gynaecologists, and the National Childbirth Trust (MCWP 2007). The statement "seeks to raise awareness that normal birth rates matter and establishes a standard definition of normal labour and birth" (G. Werkmeister, personal communication). Normal birth is a process and not an outcome measure. It is defined as a birth without induction of labour, epidural, spinal or general anaesthetic, forceps or ventouse delivery, or Caesarean section or episiotomy (MCWP 2007).

Based on this definition, the normal birth rate in England was 42% in 2011, and this figure was no higher in the rest of the UK (BirthChoiceUK 2011a). In England, the Caesarean section rate was just under 25%, and slightly higher in other parts of the country (BirthChoiceUK 2011b).

Why does normal birth matter?

A woman who has experienced a straightforward normal birth begins her life as a mother without suffering the after-effects of surgical intervention, and with the advantage of undisturbed physiological processes that support not only maternal health and well-being, but also provide a biological basis for a change in her behaviour (Odent 2013). These mechanisms increase what Uvnäs Moberg (2011) described as "calm and connection": the woman's need to protect her baby; her openness to a human relationship and love; and sensitive responses to her newborn child. A normal birth also gives the baby the best start to extra-uterine life, aiding the commencement of breathing, and that leads to the classic newborn behaviour – the wide-awake gaze of the calm, quiet and alert baby – that is designed to tug at the heart strings, particularly of the mother and father, but actually of all those in attendance.

For example, neurohormones such as oxytocin are important not only for the physical effects that these have, such as aiding the progress of labour and preventing postpartum haemorrhage, but also as a biological foundation of the mother's love for her child (Uvnäs Moberg 2011). This is the basis for the formation of the loving attachment that is important to the survival of the baby and forms a template for future relationships. To support levels of natural oxytocin, women need warmth, relaxation and freedom from fear, as well as few interventions as possible. Interventions such as the use of synthetic oxytocin, epidural anaesthetic and Caesarean section disturb the physiological processes of pregnancy, labour and birth, as well as those of the postpartum period and breast-

feeding, all of which disrupt the biological basis of maternal behavioural change.

With appropriate support, and the right environment and place of birth, women are more likely to progress in labour, less likely to need synthetic oxytocin, less likely to need an epidural or other form of analgesia, and more likely to have a normal birth. At the very least, mothers should give birth in a place where they feel safe; for some, this is at home or in a birth centre, and for others, this is in hospital. The birth room should be warm, dimly lit, as silent as possible, private and offer the use of warm water.

It is not only because interventions disturb the physiological processes, but also because commonly used techniques such as epidural anaesthesia, assisted birth and Caesarean section involve a risk of complications, that these should be avoided whenever possible (Page 2013). To take Caesarean section as an example, there is an associated chance of bleeding thrombosis and infection for the mother, as well as a danger of uterine rupture, placenta praevia and accreta in subsequent pregnancies. For the baby, there is an increased risk of foetal respiratory distress syndrome, pulmonary hypertension, iatrogenic premature birth, and difficulty with bonding and breastfeeding (RCOG & LSHTM 2013).

Moreover, a normal birth costs less, and with an increase in the normal birth rate, the general complexity of care is decreased and pressure on the maternity services becomes less intense.

Supporting normal birth

There is considerable knowledge about the ways in which normal birth and a positive experience may be supported, and the risk of interventions decreased. These include the avoidance of electronic foetal monitoring, a shared philosophy of the importance of normal birth, and the use of non-pharmacological approaches to support women in order to help them cope with contractions, including water, and a calm environment with freedom to move and to rest. However, I will focus here on the evidence for the effect of midwifery-led care, birth outside an obstetric unit (e.g. at home, or either in a free-standing midwifery-led unit or alongside one), and constant, high-quality support in labour on normal birth rates and a reduction in interventions.

Place of birth

Of the above-mentioned factors, the greatest impact on normal birth rates and a reduced risk of interventions such as assisted birth and Caesarean section is made by place of birth, specifically birth outside of obstetric units. The Birthplace in England national prospective cohort study (BECG 2011), a large, high-quality survey comparing the safety of different planned places of birth at the start of care in labour for low-risk women, evaluated the outcomes of birth at home, and in free-standing midwifery units or alongside these. The study included 64 538 low-risk women in the National Health Service (NHS) in England. The conclusion based on the findings was that mothers should be offered a choice of birth setting. Those intending to give birth in a midwifery unit, multiparous women planning a home birth and nulliparous woman preparing to give birth in a midwifery unit all underwent fewer interventions and this had no impact on perinatal outcomes. For nulliparous women who were planning to give birth at home, there are fewer interventions, but poorer perinatal outcomes (BECG 2011).

While the results of the Birthplace in England study indicated a reduction in interventions, including Caesarean section, systematic reviews of research into midwifery-led continuity of care have demonstrated an increase in the normal birth rate and a reduction in interventions, but no significant fall in the Caesarean section rate. However, this form of care has a number of advantages.

Midwifery-led care

The Cochrane Review by Sandall *et al.* (2013) described midwife-led continuity models as follows:

> ''The philosophy behind midwife-led continuity models is normality, continuity of care and being cared for by a known, trusted midwife during labour. The emphasis is on the natural ability of women to experience birth with minimum intervention. Midwife-led continuity of care can be provided through a team of midwives who share the caseload, often called 'team' midwifery. Another model is 'caseload midwifery', which aims to ensure that the woman receives all her care from one midwife or her or his practice partner. Midwife-led continuity of care is provided in a multidisciplinary network of consultation and referral with other care providers. This contrasts with medical-led models of care where an obstetrician or family physician is primarily responsible for care. In shared-care models,

> responsibility is shared between different healthcare professionals.'' (Sandall *et al.* 2013, p. 2)

This review was based on 13 international trials and included over 16 000 women. In association with midwifery-led continuity models, it was found that individuals were less likely to need regional analgesia, episiotomy and instrumental birth. Women were also less likely to experience foetal loss before 24 weeks and preterm birth. The individuals were more likely to have no analgesia or anaesthesia, a spontaneous vaginal birth, attendance at birth by a known midwife, a longer length of labour, and a higher level of satisfaction. Care was also more cost-effective.

The authors of the above study concluded that most women should be offered midwife-led continuity models of care, but that caution should be exercised for those with substantial medical or obstetric complications (Sandall *et al.* 2013).

A randomized controlled trial (RCT) of caseload or one-to-one midwifery care in Australia by Tracy *et al.* (2013) was published after Sandall *et al.*'s (2013) Cochrane Review. This RCT included 1748 women who were randomly assigned to caseload midwifery and standard care, and the authors found that fewer women had elective Caesarean section with caseload care. Care was safe and there were lower costs for individuals receiving caseload care.

An analysis of why midwife-led care is effective by Devane *et al.* (2010) concluded that this was because it is mediated by human relationships, that both midwives and women felt they had agency, and many of the services were small in scale. However, these authors did warn of the potential for conflict between different parts of the organization in cases in which there were different models.

Therefore, there is strong evidence for the provision of midwife-led care. It is safe and offers a positive experience, there are fewer interventions, and it has a number of advantages, including fewer preterm births and foetal loss before 24 weeks, and being a cost-effective form of care.

The quality of constant support in labour

While the above studies illustrate the positive effects of midwife-led care for low-risk women outside of the obstetric unit, as well for those with mixed risk, it is important to remember that, without altering place of birth or restructuring the service, the provision of constant support in labour will maintain the normal birth rate and offer a more positive experience (Hodnett *et al.* 2007). Recently, some unique research has been conducted on the quality of this form of support in labour and the effect of different levels of it.

Ross-Davie *et al.* (2013) described the development, testing and validation of a systematic observation instrument. They reported that the use of this tool contributed to the knowledge of the nature of the intrapartum support provided by midwives working in the NHS in Scotland, and the relationship of the nature of the support with key outcomes. Large amounts of data were collected regarding the presence or absence of the midwife, the frequency of positive and negative behaviours, and the frequency of care activities. Women participants appeared to value emotional support, particularly the building of a rapport, most highly in the care that they received (Ross-Davie *et al.* 2013).

Conclusion: the need to widen access to care that supports normal birth and positive experiences

Too few women in the UK have a straightforward normal birth, and access to the services that make this most likely is limited. I have mentioned a number of approaches that will increase the possibility of a normal birth for individual women and provide them with a good birth experience. These include apparently simple things such as a calm environment with freedom to move and to rest, and non-pharmacological support to help them cope with contractions, such as water and avoidance of electronic foetal monitoring.

However, the greatest impact in terms of avoiding the risks of intervention and increasing normal birth rates comes from midwifery-led care outside of obstetric units at home birth, or in free-standing midwifery units or alongside these units. Midwifery-led continuity of care is created through a different pattern of practice. It is associated with an increase in the normal birth rate and a decrease in the rate of interventions, but not with a significant reduction in the Caesarean section rate.

At present, only a minority of women in the UK have access to care outside of obstetric units or midwifery-led continuity of care. Access should be widened so that this form of care is available for all individuals who have undergone

straightforward pregnancies. This will not only increase the rates of normal birth and ensure a greater number of positive experiences, but it will also reduce pressure on complex services and be more cost-effective.

At the very least, every woman should have the constant support of a midwife who is able to develop a rapport with her, and provide positive support and care during labour, birth and afterwards. This will ensure that women have the best possible birth experience and all those who have undergone a straightforward pregnancy have the best chance of a normal birth. Furthermore, recognizing that quality of care affects the way in which a woman mothers her baby and feels about parenting will guarantee that she receives the best possible care, which contributes to a healthy birth, secure family attachments and the most successful start to family life.

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