THE BLOG

Getting To Grips With The 'Normal' Birth Debate

One argument seems to be that it makes some women feel abnormal if they don't give birth naturally. Given the statistics, this would make the majority of UK mothers 'abnormal'. The term 'normal' is not a judgement on an individual, but a statement of physiological fact about a particular bodily process.

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In 2001, the Royal College of Midwives set up a campaign to help midwives to support women who wanted a normal birth, following research which found that only about one in every three women experienced a birth without interventions. Recently, the UK media claimed that this campaign catalysed a 'cult-like fixation' on 'normal' births. Associations were made between the normal birth campaign and stillbirths and brain injury to babies, despite falling stillbirth rates in the UK over the last few years, and no evidence of a change in the rate of brain damage in babies.

Of course, normal birth is not the right option for everyone. Complications can mean that medical assistance is needed, and, unless the woman objects, maternity care staff should all ensure that women receive effective interventions in this circumstance. Some women choose interventions for personal reasons. However, the vast majority would prefer to give birth with the support of caring, competent staff and supportive companionship, and without drugs or technical or surgical techniques, where this is safe for their baby. Professional obstetric, midwifery and paediatric organisations, as well as national guideline bodies, in the UK and overseas, all agree on the benefits of birth without interventions where this is safe, and the preference of the mother. Safety, in this context, includes better clinical, psychological, and emotional outcomes in both the short and longer-term, for both mothers and babies.

Unfortunately, however, physiological labour and birth may be the least common option available. The UK Which BirthChoice site reveals that the rate of women who are supported to give birth with minimal interventions is still only around 1:3, and this rate is much lower in some hospitals.

And now the very use of the term 'normal birth' has come under scrutiny. This is despite the fact that most women use terms like 'normal' or 'natural' to talk about this preference. One argument seems to be that it makes some women feel abnormal if they don't give birth naturally. Given the statistics, this would make the majority of UK mothers 'abnormal'. The term 'normal' is not a judgement on an individual, but a statement of physiological fact about a particular bodily process.

Some media cite traumatic vaginal births as evidence of the dangers of normal birth. However, normal birth and vaginal birth are not the same thing. Vaginal birth can follow a whole cascade of labour interventions, including forceps, and it can be far from positive if staff have been uncaring. If women who experience this are told they had a "lovely normal birth" it is unsurprising that they may see normal birth as something to be avoided, then go on to book an elective cesarean for their next baby.

Claims have also been made that an emphasis on normal birth leads midwives to be cavalier by relying on a 'wait and see' approach with regards to labour. This is despite the fact that watchful waiting has long been recognised as a high-level skill in general medicine - it includes careful observation and monitoring, with a view to intervening where necessary. It certainly isn't wishful thinking. It is an expert attribute, that requires years of learning and experience in a range of complex situations.

Continuity of midwifery care through pregnancy and birth, in the context of good links and relationships with medical staff, has been shown to reduce prematurity, reduce overall fetal and neonatal loss, increase normal birth, and increase women's sense of a positive labour and birth. The expert, intuitive judgment used by both midwives and obstetricians to assess what is happening in the unique labour and birth of each individual mother and baby, along with the formal evidence base that applies to the majority of laboring women and babies, means that they can judge when a mother and her baby may not be coping well with labour, and act on that judgement.

These beneficial effects of skilled, expert, attentive midwifery care depend on the midwife being able to spend time with the laboring woman, to ensure recognition of the subtle signs of wellbeing or complications in her and her baby, rather than being somewhere else filling out forms and computer screens. Because this kind of care isn't a drug or a bit of kit, it is

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sometimes considered to be a luxury and something to think about providing only if there is some resource left over when all the latest technology and paperwork has been introduced.

Medical drugs and/or technical proceedures are very necessary for the wellbeing of a minority of women and babies. However, increasingly, expensive interventions that are designed for the needs of the minority are used 'just in case' for the majority, eventually becoming the 'norm' for all, making physiological birth less achievable, and rendering maternity care less and less sustainable. As this technology moves midwives further from the woman, and closer to checklists and computers, women and babies experience less support, and, consequently, more intervention. This is less safe for the majority, and leads women to associate 'normal' with 'traumatic'. It also uses up NHS resources that could otherwise be used for mothers and babies who really need additional support. Indeed, Conrad and colleagues estimated that, in 2005, the USA spent over $18 billion on unnecessary interventions in normal pregnancy and birth. Ensuring that only those who need (or want) childbirth interventions get them is likely to free up considerable resources to treat those with real need in the NHS, as well as in countries like the USA.

We are in a maternity world where we promise information and choice, but often make it impossible for many women to have the kind of birth they want. Whatever we decide to call different kinds of birth, for the sake of every woman and every baby, it is now time for balanced reporting and policy change in this area. All those who want to improve maternity care, and outcomes for mother and baby, need to move to a both-and message. This is about both safety and positive experience; both mother and baby; both clinical and psychosocial outcomes; both short and longer-term benefits. This is what women and families want and need.

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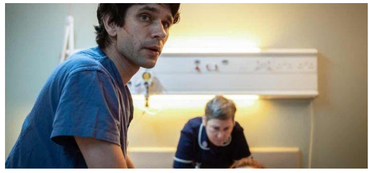

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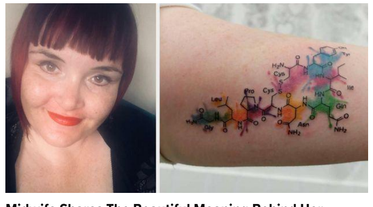

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