commentary

Normal Birth

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Despite considerable debate and research over many years, the concept of "normality" in labour and delivery is not standardized or universal. Recent decades have seen a rapid expansion in the development and use of a range of practices designed to start, augment, accelerate, regulate, or monitor the physiological process of labour with the aim of improving outcomes for mothers and babies ….[1]

The statement above begins the preamble of *Care in Normal Birth: A Report of a Technical Working Group*, published by the World Health Organization (WHO).[1]

In our fast-paced, high-technology world, we have difficulty agreeing on what constitutes "normal birth." For some, the term is an oxymoron because they believe—as does an obstetrician friend of mine—that "pregnancy is a disease." For the purpose of this editorial, normal birth is defined as low-risk pregnancy with spontaneous onset of labor occurring between 37 and 42 weeks' gestation. Labor is allowed to progress on its own with the free movement and positioning of the mother throughout. After birth, the mother and infant are in good condition and are allowed unlimited time for breastfeeding and initiating bonding. The World Health Organization estimates that between 70% and 80% of women entering labor are at low risk.[1]

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The birthing environment has changed in the more than 40 years that span my career. These changes have been influenced by many things—some helpful and progressive , others challenging or even detrimental. In the 1960s, change was consumer-driven: Women began to demand a stronger voice in choices regarding labor and delivery. They refused to be medicated without their permission: They wanted to remember the birth experience. Mothers found it unhelpful to progress through labor only to be given a saddle block just before delivery and to have the baby delivered by forceps or vacuum extractor. They wanted the support of their loved ones throughout the labor and delivery process. The significance of bonding was emphasized. Breastfeeding on demand was a goal. And women wanted these options made available to them in the hospital where they would give birth: They wanted the safety net of modern medical knowledge. The prepared childbirth movement helped push these choices into hospital practice.

Our ability to safely manage pain in the form of intrathecal and epidural anesthesia has changed the birthing environment; with this change, however, we see prolonged labor curves, an increase in instrument-assisted delivery, and a suspected increase in the rate of cesarean birth. Currently, the rate of cesarean birth is 26.1%, the highest ever in the United States.[2] At the same time, the rate of vaginal birth after cesarean (VBAC) has fallen precipitously to 12.6%.[2] The *Healthy People 2010* expert working group (including representatives from the American College of Gynecology [ACOG]) recommended a target national cesarean delivery rate of 15% and a VBAC rate of 37%.[3]

Another change is today's adversarial legal environment, which results in astronomical increases in malpractice premiums. This result forces many obstetric providers to leave their obstetric practice. In addition, the physicians and midwives who remain may be more likely to practice defensively. Believing that technology will protect us from adverse outcomes, we have developed a strong reliance on it. Using information gathered on all births in 2002, the latest data from the US Centers for Disease Control and Prevention (CDC) *National Vital Statistics Report* shows that use of electronic fetal monitoring has increased from a rate of 68.4% (in 1989) to 85.2% (in 2002).[2] This increase has occurred despite prospective randomized controlled trials being conducted in more than 18,000 patients and showing that immediate and long-term outcomes for high-risk and low-risk women were not improved by use of electronic fetal monitoring compared with intermittent auscultation and that electronic fetal monitoring increases the rate of cesarean births substantially.[4] The number of

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women receiving ultrasonographic evaluation in this same period increased from 47.7% to 68%.[2] Induction of labor for all gestational ages (including premature infants below 37 completed weeks of gestation) increased from 9.0% (in 1989) to 20.6% (in 2002), a 129% change.[2] In upstate New York, where the regional induction rate was approximately the same as the national average, a study of 31,352 deliveries evaluated variation in rates of induction by hospital and practitioner and found that 25% of inductions were for no apparent medical indication.[5]

Although change in use of technology in the birthing environment has mushroomed, the infant mortality rate (defined as the number of infant deaths in the first year per 1000 live births) has changed very little since 1990 and has actually increased from 6.8 (in 2001) to 7.0 (in 2002).[6] The March of Dimes Perinatal Data Center still lists the United States as 28th among countries reporting infant mortality data to the WHO.[7]

Rates of maternal mortality (number of maternal deaths from complication of pregnancy per 100,000 live births) has decreased 99% since 1900 from 850 maternal deaths to 7.5 maternal deaths. However, for the last 22 years—specifically, since 1982—we have seen very little further progress: The maternal mortality rate varies from six to eight maternal deaths per 100,000 live births.[8]

What does all this have to do with Kaiser Permanente? Our business is health maintenance. Keeping birth normal seems to me not only an obvious goal but also a cost-effective one. What can we do to promote, protect, and support "normal birth"?[9]

From the beginning of pregnancy, we can encourage open and honest communication by discussing and explaining what is happening and why. Knowledge reduces fear and anxiety and improves compliance. Encouraging mothers to review with us a personalized birth plan prepared during pregnancy furthers communication and offers a way to discuss realistic expectations. Risk must be assessed prenatally and updated at each contact and during labor and delivery. These risks should be discussed with the mother and her family *dispassionately*, allowing for realistic adjustments in the plan for birth.

We must empower mothers with the belief that their bodies are made to give birth …

Providing continuous attendance by someone trained in labor support (such as a doula, a nonmedical labor assistant whose role is to comfort and support the mother and father during birth or to care for the mother and newborn infant) may help the mother to reach her birthing goals and substantially improves families' satisfaction with their experience. We can periodically update our repertoire for labor support—including use of noninvasive, nonpharmacologic methods of pain relief—particularly if the goal is a minimally interventive birth.

We must empower mothers with the belief that their bodies are made to give birth and, in most circumstances, will do that well. We must dissipate the idea that without our high-technology intervention, babies cannot be born healthy and safe.

We can make our intervention minimal and noninvasive and progress to use of technology only when needed. We can let labor start on its own when there is no medical indication to induce. Using standardized definitions of fetal heart rate patterns and working to agree on the meaning of these patterns in terms of what intervention, if any, is needed may help to reduce inappropriate intervention.[10] We can become more comfortable with using intermittent auscultation when this can be done appropriately and safely. Mothers should be allowed—and actually encouraged—to have freedom of movement and position throughout labor. We must determine if and when intravenous fluids should be initiated and if and when other sources of fluid and nourishment are appropriate. We need more information on the appropriate use of amniotomy before using this procedure routinely during labor. We must recognize that pulling or stretching the perineum probably does not help the baby to descend more quickly and does not protect the perineum. We must remember that the baby belongs to the mother and not to us. With adequate drying and stimulation, placing the normal baby skin-to-skin with the mother provides a great warmer and a chance to let the mother begin the bonding process. This practice also facilitates breastfeeding initiated within the first hour of birth.

Our job at Kaiser Permanente is health maintenance, and we are great at doing this in high-risk, dangerous situations for mothers and babies. I hope we can be equally as good at providing this health maintenance for low-risk mothers having a "normal birth." It makes sense, it's cost-effective, and it's the right thing to do. ❖

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A Convenient Time

Death and taxes and childbirth!
There's never any convenient time for any of them.

— Gone with the Wind, *Margaret Mitchell, 1900-49, American author*