



# A Better Birth

*Medical interventions have their place. But simpler, healthier birthing options abound — and they're becoming more popular. Want to make your pregnancy and labor as safe and empowering as possible? Consider your choices, including the birthing partners, plans and environments that suit you best.*

By KARA DOUGLASS THOM

When Lizzy Moxey was pregnant with her first child in 2002, a friend gave her an article about Michel Odent, MD, a pioneering French obstetrician who transformed the way his hospital treated birth in the 1960s. Challenging conventional obstetrical practices, Odent minimized medical interventions and encouraged women to believe in their abilities and trust their instincts.

"I read the paper cover to cover, and I was hooked," Moxey recalls. She and her husband opted to give birth at a midwife-staffed birthing center near their Sydney, Australia, home.

"My midwife literally gave us the skills and science behind birth and told us that the body will work with you to get the baby out," Moxey says. "She spent a short time talking about drug options and C-sections, but it was assumed these were not necessary."

On the day she gave birth, Moxey labored at home for several hours and arrived at the birth center an hour before delivering a 9½-pound baby girl. "There were no drugs on hand — just a pool, a Swiss ball, a birthing chair," she says, adding that she held her daughter right away and began nursing within minutes. "I just think that many women are missing out on a wonderful experience because they are not being supported or given the skills to birth in a normal way, unless they make the effort to find out about it themselves."

Like Moxey, more and more women are exploring ways to regain control over their birthing experience.

Conventional hospitals and physicians, many claim, treat birth as an illness, not as a natural process.

As a result, the vast majority of expectant mothers do not have a "normal" birth, according to Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences, conducted by Childbirth Connection and Harris Interactive in partnership with Lamaze International. (Find more at [www.childbirthconnection.org](http://www.childbirthconnection.org).)

In fact, only 2 percent of American women who gave birth at a hospital in 2005 experienced what the World Health Organization (WHO) defines as a normal birth — one that begins spontaneously between 37 and 42 weeks of gestation with the baby in the "head down" position, stays low-risk during labor and birth, and allows mother and child to stay together after the birth. Interventions, if any, are only performed when medically necessary.

The label "normal" isn't meant to insinuate anything else is "abnormal," but merely to define the physiologic process as nature intended it. A normal birth isn't always a natural birth, either. In rare cases nature doesn't work — and an epidural, episiotomy or cesarean becomes necessary.

Modern medicine has certainly provided a safety net in cases where childbirth might have ended badly, but today the vast majority of American births occur as part of a collection of invasive processes. About one in three American babies is delivered via cesarean section; about four in 10 mothers have their labor medically induced (of those, synthetic oxytocin — Pitocin — is used 80 percent →



of the time). One in four mothers undergoes an episiotomy before delivering, and more than 75 percent of deliveries involve continuous electronic fetal monitoring (EFM).

Just one unnecessary intervention can lead the expectant mom into a situation that prevents her from birthing normally. And sometimes that single intervention leads to the *medical* necessity of another, sparking what many birth-reform advocates refer to as a "cascade of intervention" that can lead to some decidedly unhealthy outcomes.

Avoiding those interventions and the outcomes they often produce takes some research and planning — birthing options are not always well promoted — but the decisions you make now can make all the difference when it's time to give birth.

### *You Do Have Options*

Your odds of having a normal birth typically depend on your doctor or midwife, says Henci Goer, author of *The Thinking Woman's Guide to a Better Birth* (Perigee, 1999). "Whether a woman has a cesarean or not has very little to do with her health and everything to do with her care provider's practice philosophy," says Goer.

So women should choose their physician carefully and consider hiring a doula, someone trained to comfort birthing women for the duration of their labor and birth. Another option is to turn to midwifery.

Like physicians, midwives provide prenatal care and guidance for expectant mothers. But midwives also offer continuous hands-on assistance throughout labor and delivery, as well as comprehensive postpartum support. They attend about 10 percent of births in hospitals, homes and birth centers.

"Birth centers are more like a maxi home than a mini hospital," explains Kate Bauer, executive director of the American Association of Birth Centers (AABC), which supports the 185 accredited U.S. birth centers, where about 20,000 women give birth each year. "Birth centers look at birth as normal until proven otherwise."

While some hospitals may tout their maternity wards as "birth centers," they are typically governed by hospital policy, as opposed to birth center standards, which give a woman control over her birth experience.

Traditional birth centers are "low-tech, high-touch" facilities located near hospitals (in case of medical emergencies) and are staffed by midwives and nurses. They often are modified homes, complete with living areas and a kitchen. Because women also receive their prenatal care there, they give birth in a familiar place.

"A birth center is more about a program of care," Bauer says. "If a birth center is touting the latest in technology, then it's not a birth center that follows the AABC model."

The midwifery model of care is far from experimental. In fact, in many countries it is standard practice. In Europe, for example, midwives attend some 70 percent of births (physicians there are called consultants) and maternity outcomes are the best in the world, including far fewer nonemergency cesareans and a lower infant-mortality rate.

### *Striving for a Normal Birth*

Despite these options, the vast majority of expectant women in the United States will give birth in a conventional hospital with a physician presiding. This does not mean you must settle for anything but the best birth experience and outcome. To get there, however, you first need to understand what factors prevent a normal birth and how to avoid them.

Based on WHO's definition, the Lamaze Institute for Normal Birth cites these six standards for a "normal" birth:

1. Labor begins on its own
2. Freedom of movement during labor
3. Continuous labor support
4. No routine interventions
5. Non-supine (for example, upright or side-lying) positions for birth
6. No separation of mother and baby immediately after birth

Here's how to ensure those standards are met in your birthing experience ...

## 1. *Labor* begins on its own

Sometimes physicians, or their patients, will look for reasons to induce labor toward the end of pregnancy. In 1989, only 9 percent of births were

induced. By 2002, inductions more than doubled to 20.6 percent, and now, five years later, they have nearly doubled again — mostly for nonmedical reasons. The rise in labor induction is directly related to the rise in cesarean sections, because inducing can put both mother and child in distress. Instead of choosing a conventional induction, consider the following options:

- Be patient. A 2002 study showed a median pregnancy length of 41 weeks plus one day in women who had never given birth before, and a 40-week, three-day average pregnancy length in experienced mothers. Medical inductions usually are warranted after 42 weeks because of an increased risk of stillbirth (caused by a decreased flow of oxygen and nutrients through the placenta).

- Prostaglandin, the hormone in cervical-ripening drugs, is naturally found in semen, while oxytocin, which is used to induce labor, is naturally produced during orgasm and, sometimes, nipple stimulation. Often, all-natural sex can do the job of these drugs.

- Your physician or midwife can “sweep” the membranes during an internal exam, using a finger to swipe the cervix, which sometimes initiates labor within a few days.

## 2. *Freedom* of movement during labor

If a woman is in bed during her labor, she loses the advantage of having gravity on her side. And two common birthing strategies — continuous electronic fetal monitoring (EFM) and epidural anesthesia — keep you on your back. To get moving while in labor, try the following options:

- If your caregiver advises EFM and you’re not considered high risk, request intermittent monitoring instead.

- If you need pain relief, try noninvasive measures first: a massage, shower or bath; changes in position; or techniques offered by various birthing methods. Ask your caregiver about the availability of other drug-free options such as acupuncture or sterile water injections.

- Some women may still want or need a medicated labor and delivery, but before calling on the “big guns” of an epidural,

consider Nubain or Demeral, narcotics that can provide relief with fewer side effects and adverse reactions.

## 3. *Continuous* labor support

Several studies report that women who use a doula during childbirth experience less pain and, therefore, have fewer requests for pain medication and anesthesia; have less need to stimulate the labor process with medication; and require fewer cesarean births. Midwives produce similar outcomes, perhaps also as a result, in part, of their continuous presence.

“I couldn’t have asked for a better support network,” says Savage, Minn., mom Jaime Stokes, 37, about the midwives who helped her through three births. “The personal care they gave me — from back rubs to a full-fledged cheering section — was amazing. They garnered my complete trust, which decreased my anxiety and led to less pain. I always felt safe and knew my babies were safe.”

In order to get good support while in labor, try to:

- Choose a physician or midwife who shares your philosophy so you both know what kind of support will be provided and expected. Don’t hesitate to change caregivers during your pregnancy if you don’t feel comfortable with their approach.

- Hire a doula. If you can’t afford one, doulas-in-training usually attend births for free or at a reduced cost.

- Surround yourself with positive messages and images during pregnancy and labor, and have a mantra you can repeat. Above all, believe in yourself. →



## 4. *No routine interventions*

Emergencies sometimes occur in childbirth. And intervention in those instances can save lives, says Kenneth Leveno, MD, coauthor of the *Williams Manual of Obstetrics* (McGraw-Hill, 2007) and chief of obstetrics at the Parkland Health and Hospital System in Dallas. “They’re rare, yes, but as physicians we need to be able to provide the care necessary for that rare baby,” Leveno says. “To do that, you have to practice interventions before the catastrophe occurs. It’s the only way you can deal with uncertainty.”

Increasingly, however, many observers say, these preemptive strikes are intruding on what could be normal births. For example, physicians performed an episiotomy — a surgical cut to the area between the anus and vagina during labor — on some 25 percent of the women polled in the Listening to Mothers II survey — even though the procedure is only necessary in less than 10 percent of vaginal births. Studies suggest that births assisted by midwives are five times less likely to involve episiotomies than those handled by obstetricians.

The procedure is designed to ease difficult deliveries, but it can result in more severe tearing, blood loss, infection, urinary and fecal incontinence, and painful intercourse.

To avoid an episiotomy, work with a midwife or be sure your physician knows you do not want an episiotomy unless a medical emergency requires it. Also, to avoid tearing during delivery, try the following options:

- It takes time for the perineum to stretch. By laboring upright as much as possible, you let gravity work in your favor.
- Ask your birth attendant to hold the baby’s head so that it more slowly and gradually eases through the vaginal opening.

- Perineal massage at the end of pregnancy and during labor can help stretch and prepare the perineum for delivery. (Find more at [www.childbirth.org/articles/massage.html](http://www.childbirth.org/articles/massage.html).)

Cesarean section is another intervention that is on the rise — from about 5 percent in 1970 to more than 30 percent today. (By comparison, the cesarean rate at birth centers nationwide is about 4 percent.) Birth reform advocates don’t oppose cesarean surgery when emergencies arise. The real problem, they contend, is that caregivers do little to avoid it. By the time a woman has been induced, given an epidural and labored on

her back, it’s too late for anything but a surgical outcome. Hoping to avoid a C-section? Try these tips:

- Avoid interventions that put you at higher risk for a C-section, especially an induction (unless it is medically necessary). If you are attempting a vaginal birth after cesarean, you absolutely should not be induced, since it can increase your risk of uterine rupture.

- Labor at home for as long as comfortable. The later you go to your birthing place, the less likely you are to be faced with unnecessary interventions.

- A poorly positioned baby is cited as the reason for a C-section in about 25 percent of cases. See [www.spinningbabies.com](http://www.spinningbabies.com) and other resources (page 61) on encouraging an optimal position — for you and your baby — during birth.

## 5. *Non-Supine* (for example, upright or side-lying) positions for birth

“Pain can guide the woman instinctively into the movements and positions she needs to coax a posterior baby (facing the woman’s belly instead of her back) into a more favorable position for birth,” Goer says. “But with an epidural, she loses this feedback mechanism.” She notes that early epidurals increase the likelihood that posterior babies will stay that way — possibly due to lying in bed. To avoid the supine position, try the following tips:

- During pregnancy, spend time in positions that help the baby position itself correctly. These include child’s



pose; on hands and knees; sitting forward in a chair; sitting cross-legged; or squatting.

- Avoid an epidural or other interventions that would keep you immobile, and enlist someone on your support team to help you try more comfortable positions.
- Ask for a squat bar, which is designed for women to assume a more upright position during the pushing stage.

## 6. *No separation* of mother and baby immediately after birth

A healthy newborn should be placed skin-to-skin on the mother's abdomen or chest as soon as he or she is born. There, the baby can be dried, covered with warm blankets and allowed to begin breastfeeding.

To avoid separation, try the following options:

- Avoid a planned C-section and other interventions, which could lead to complications that may require mother or baby to receive special treatment in different areas of the hospital.
- Make sure your provider and the hospital have a copy of your birth plan, which includes your expectations for care of a healthy baby.
- Request that any tests or procedures that can wait *do wait*. Opt out of any optional procedures you prefer to avoid altogether.
- You can go against "hospital policy," but you may need to sign a waiver. If you can't deviate from policy, or you sense resistance, consider birthing elsewhere.

### *Powerful Choices*

Ultimately, an informed mother-to-be decides what is "normal" for her. Diane Petersen, MD, a partner in a Minneapolis, Minn., obstetrics and gynecology practice, says she believes in supporting and advocating normal birth as outlined by WHO and Lamaze International, but it's her philosophy to help patients individually. "It's our job to support women in their decision making," she says, "and the goal is to make them feel powerful and successful in whatever they choose."

As for Lizzy Moxey, she wouldn't trade the way she brought her daughter, Harriet, into the world for anything. "The bond I have had with my daughter from day one is huge," she says. "And I just honestly feel like my birthing experience made the bond closer." ●

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## *Birth Preparation:* Five Steps to Success

### 1. CHOOSE A PROVIDER AND PLACE TO BIRTH.

The Coalition for Improving Maternity Services has suggested questions to ask potential providers at [www.motherfriendly.org/resources/100](http://www.motherfriendly.org/resources/100).

### 2. RESEARCH VARIOUS BIRTH METHODS.

Informational online resources include the Bradley Method of Natural Childbirth ([www.bradleybirth.com](http://www.bradleybirth.com)), Childbirth Connection ([www.childbirthconnection.com](http://www.childbirthconnection.com)), HypnoBirthing: The Mongan Method ([www.hypnobirthing.com](http://www.hypnobirthing.com)), and Lamaze International ([www.lamaze.org](http://www.lamaze.org)).

### 3. FIND A DOULA.

Ask for referrals at your childbirth class or prenatal exercises classes, or from your provider; search online at DONA International ([www.dona.org](http://www.dona.org)), a worldwide, nonprofit organization of doulas.

### 4. CREATE A BIRTH PLAN.

An interactive tool available at [www.childbirth.org/interactive/ibirthplan.html](http://www.childbirth.org/interactive/ibirthplan.html) can help you select various birthing options, including:

- Maintaining mobility (for example, if you get an epidural, mobility will be severely limited)
- Fetal monitoring (for example, continuous or intermittent)
- Pain relief (for example, nonmedicinal measures such as a shower or a massage, or medicinal drugs such as Nubain or an epidural)
- Induction (for example, natural methods such as nipple stimulation or walking, or medicinal measures such as Pitocin)
- Episiotomy (for example, do you prefer an episiotomy or do you opt for natural methods, such as massage and warm compressions, to prevent tearing?)
- Cord cutting (for example, immediately, or after you've held your baby for a while)
- Separation after birth (for example, no separation at all, separation only at night, etc.)

### 5. READ WHILE YOU GESTATE.

Get educated about your birthing options with help from these books:

*Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First* by Marsden Wagner, MD, MS (University of California Press, 2006)

*Childbirth Without Fear: The Principles and Practice of Natural Childbirth* by Grantly Dick-Read (Pinter and Martin, 2005)

*Ina May's Guide to Childbirth* by Ina May Gaskin (Bantam, 2003)

*Baby Catcher: Chronicles of a Modern Midwife* by Peggy Vincent (Scribner, 2002)

*The Thinking Woman's Guide to a Better Birth* by Henci Goer (Perigee, 1999)