Helping Women Achieve What They Want in a Hospital Birth: *Education not Alienation*

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There is a line in Karen Brody's play, BIRTH, that Jillian DeMoya's character proclaims after witnessing her first home birth, "I want what she got!"

Today, with more and more media attention given to home birth, gentle birth and waterbirth, women across the country are asking how to get that type of experience in their local hospitals. Hospitals and providers have questions, too, and some places are actually changing to accommodate women's choices. There are innovative hospitals like Woodwinds Health Campus in Woodbury, Minnesota, where alternative health and complimentary modalities have been embraced, including waterbirth.[1] But the typical response is, "we don't offer that here." Portland, Oregon, perinatologist and head of Women's Services for Legacy Emanuel Hospital, Duncan Neilson, stated in a presentation that he gave on hospital waterbirth, that it is "the mission of the hospital to serve the community, and if the community is asking for more home births, then it should be the duty of the hospital to make the birth experience for those women who choose to birth in that hospital more like home, including the use of water."[2] With this attitude, every hospital would clearly be more capable of fulfilling it mission to serve the community.

A more recent experience is one that a mother from Abilene, Texas recounted in an email when she took a packet of downloaded materials on waterbirth to her physician and asked him to consider supporting her in using water for labor and possibly birth. He pushed the packet back to her without opening it and stated, "I deliver women on their backs with their feet up in stirrups, and if you have a problem with that, find another doctor." In her email she stated, "I guess I won't get what I want this time."

So, then the problem is defined as, how do we as childbirth educators and advocates of gentle birth help women approach hospitals today in getting what they want? For almost three decades I have been working with birthing families to help them advocate for the use of warm water immersion as a pain management tool in hospitals, homes and birth centers and have learned how to approach hospitals and on many occasions what not to do.

I did counsel the woman from Abilene to find a nurse-midwife or physician who would be more open to her request, or to even consider staying at home, but she was limited by her insurance and her due date was looming on the calendar not providing adequate time to prepare the groundwork necessary for making such a huge leap that the hospital would have to make before "allowing" her to bring in a portable pool. The mistake that many women make is coming in with a list of demands, which immediately alienates whether provider or hospital.

It is safe to say that we all want change to occur in hospital settings and many organizations and advocacy groups are approaching these issues and making them priority. In this turbulent time of health care reform debate, more emphasis than ever before is being given to improving maternity care, decreasing infant mortality and premature birth and ensuring that maternity care is provided in ways that are safe, effective, woman-centered, timely, efficient and equitable. Like the veritable elephant in the room, each of us is tackling a different aspect of the problem. In August, the American College of Obstetricians and Gynecologists, released a statement actually relaxing their rule on no fluids in labor to now allow clear liquids.[3] It was a monumental step, but far

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from timely considering the volumes of evidence that have supported the intake of both food and fluids for laboring women.

Using the trump card of evidence-based medicine (EBM) is a tricky thing. Doctors have not changed their practices based on the accumulation and analysis of data and like the doctor in Abeline, some are not even open to reading new data on practices that have been accepted as standard in other parts of the world. John Thorp, MD, editor of the prestigious *American Journal of Obstetrics & Gynecology*, stated in a November 2008 editorial that evidence-based medicine "is an outgrowth of the 20th century Western's world embrace of modernity based on the belief that by compiling, categorizing, synthesizing, and grading the medical literature the wisdom accumulated in the synthesis would move medical practice away from its anecdotal and traditional roots into a golden age of rationalism."[4] He continued his discussion by comparing our misguided assumptions that providers would have the desire to upgrade or modernize their practice based solely on the evidence to the famous role that Kevin Costner played in *Field of Dreams*, where he was directed to build a baseball diamond in the middle of an Iowa cornfield. You hear the words in the film repeatedly, "build it and they will come." Providers have not come around and there is no proof that modern obstetric practices are based on the evidence of their effectiveness. It is just the opposite today with mounting evidence that some practices bring harm, should be changed and a new attitude of acceptance of alternative modalities should be in place.

The most common reason that hospitals give for not offering waterbirth is, "no one asks for it." In the 1970s we asked for change, demanded change, even handcuffed women to labor beds so they could not be transported to delivery rooms. And we did see change, albeit cosmetic. With the increase in the numbers of practicing nurse-midwives, we also saw practices changes in some places. Today, as we encourage women to ask for change, they are baffled by the vast system of administrative rules, regulations and departments of modern hospital systems. Robbie Davis-Floyd, PhD, medical/cultural anthropologist and author of numerous books, talks about post-modern practices that teach us that not only are evidence and studies important, but that to change practice we must enter into a dialogue. She explains that we must acknowledge what is good and right and true and empirically proven from the pre-modern era and combine it with our modernity, which then results in good post-modern maternity care.[5] In a post-modern world, we would take that empirical evidence from the past and combine it with those things that we revere and respect in our world today and have an end result of actual mother-friendly maternity care, with the birthing family as central to the experience.

My work has taken me to over forty countries around the world where I have engaged in dialogues with many providers and birth support people. Some things are wonderful in other places, like the national use of midwives as the gate-keepers of maternity care in Western Europe and the inclusion of water immersion in all hospitals in the UK.[6] But there are other places where the worst of Western medicine predominates, such as Turkey, where midwives were completely eliminated and the cesarean birth rate is over 80% in privately owned hospitals. In the countries with the highest cesarean birth rates, women's voices and desires are simply not part of the equation.

With over 3000 maternity hospitals offering care in the United States, less than 20% have adopted protocols for use of water as a pain management tool in labor and about half of those have added waterbirth as an option.[7] Is there evidence of effectiveness of deep warm water immersion as a useful tool in labor? Absolutely, but most of it is published in European midwifery or medical journals, which are not read or valued by U.S. obstetricians.[8,9,10] Are there requests from women wanting this option? Yes, but not enough. Most women who attend their hospital based childbirth classes never hear that it is even an option to ask for this kind of care.

At the 1995 Chicago Lamaze Conference, someone stood at the open mic in a general forum and asked the following question: "Who is this room is afraid to tell the truth to pregnant women because they might lose their jobs?" The usual chatter of a room with over 500 educators suddenly stopped. Dead silence, no one talking and no one responding, then slowly one hand went up in the front section, then another and another, until three quarters of the room had raised hands. Educators are often heard saying that the films and books on waterbirth are wonderful, but that they cannot show these in their classes for several reasons. First,

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their class time has been severely cut short and second, those options aren't offered at the hospital and they don't want to disappoint women. There is still that lingering doubt, as well, that if such a video were shown the educator may get into trouble and be asked to stop. At those fortunate hospitals where these issues can be discussed, the rate of change has been less fraught with obstacles.

The inclusion of any new policy or practice utilizes a structured system and approach that almost every single institution must follow. A great deal of the organization of policy change lies within the job description of the nurse manager of labor and delivery or the director of maternal/child health services; a job about which most pregnant women who walk onto the maternity unit, with birth plan in hand, are not aware. In small hospitals, nurse managers usually still work as labor and delivery nurses on top of all their organizational, committee and employee functions. Often a thankless job, the nurse manager position usually requires additional degrees, such as a Masters, and additional training. In a recent interview with Karen Galloway, nurse manager of the Boca Community Hospital maternity department, in Boca Raton, Florida, she explained the almost one year process that was required before "officially" welcoming a mother in labor with an inflatable pool tucked under one arm. Karen, after reviewing the entire process, boiled her success down to one thing, "You know, it was really educating the nurses and reassuring them that it was not going to be more work for them or that it was not going to be harmful for mother or baby." She went on to say, "many of the nurses on this unit, especially the more recent graduates, I am sad to say, have never witnessed a normal birth. Never seen a labor without pitocin or an epidural. And frankly, when a woman comes in here asking for an unmedicated birth or to use water, they are baffled and don't know what to do." She summed up her experience of instituting a water labor protocol by admitting, "We will do just about anything a mother wants if there is enough evidence that it is safe, but the mothers have to ask for it. We now see two or three women on every hospital tour asking if they can have a waterbirth here. As more women started asking, administration began to see that it was something that could potentially bring more revenue to the hospital." Galloway also indicated that the year long process was actually closer to three months and probably only about forty hours of work on her part after doing initial research, seeking support within the hospital and leaving for several months to have her own baby.

After calling several other nurse managers around the country, I compiled a list of the most frequently stated job descriptions. This was done to stress the importance of designating nurse managers as the hinge pin in getting policies in place, but to emphasize why it often takes so long. Pregnant women, especially those who call two weeks or even one month prior to their due dates, need to understand how their request is received and processed. Here is an abbreviated list of the responsibilities that nurse managers and heads of maternity services have on their agendas on a daily, weekly or monthly basis:

- Overall operation of the unit
- Interacting with physicians
- Responding to patient complaints and requests
- Staffing: including hiring, disciplining, training and scheduling
- Budgeting
- Quality improvement
- Problem solving
- Filling out reports and submitting them to the right departments
- Arranging for and attending meetings with administration, medical staff, nursing, education, infection control and sometimes engineering, and environmental services.

Not to mention working shifts if staffing is short. No wonder patient requests get side tracked as due dates quickly come and go!

Hundreds of women have followed my advice, used my services and allowed me to mentor them through the process of achieving a waterbirth. I have been known to say, "when all else fails, call the media." I don't like to encourage what can easily become alienation, but after months of letter writing, meetings, phone conversations and a game of what I have affectionately labeled, "hospital ping pong," (where different department heads blame each other for not being able to get a protocol in place, but no one is really taking responsibility and so you go back and forth from department to department) a mother in Arizona threatened to set up her birth pool in the parking lot and called the local TV station and newspaper to cover her "out of hospital birth." I had

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suggested that as a joke, but she took me rather seriously. The amazing thing about that incident is that it worked! The first waterbirth in that hospital, filmed by a TV crew, documented in the newspaper and a happy nursing staff in the end. The hospital incidentally is still providing waterbirths for those who inquire.

The four main ingredients for any woman to specifically achieve the goal of using water immersion in labor and possibly waterbirth are:

1. An awareness of the possibility through education and support
2. A relentless will from that woman to endure the process of hospital policy adaptation and adjustment
3. A cooperative provider who will read the research, become educated and possibly allow someone to proctor or mentor them through the first few experiences
4. A willing nurse manager who will take the time to advocate for a new policy through the hospital system

These same four ingredients can be applied to any modality that is not currently part of normal hospital practice, such as midwifery care, doula care, acupuncture, Reiki, reflexology, sterile water papules, liberal eating and drinking in labor, auscultation of fetal heart tones, vocalizations and chanting instead of pushing, different positions for birth, abandonment of episiotomy, no cord clamping with physiologic third stage, delivery self attachment, no suctioning unless there is a necessity, kangaroo mother care, formula by prescription only, respect of the newborns' capabilities and sensitive neurological system and abandoning non-religious circumcision.

And how does the childbirth educator become a key initiator of the four steps? By taking the first step and embracing it by whole heartedly telling the truth through innovative teaching, education and mentoring. This will give women "freedom of choice based on knowledge of (all) alternatives." There has never been a time in our history with an accumulation of such clear evidence and the means to disseminate it to a misinformed public. It is quite obvious that we currently suffer from a complex societal malady called, "truth decay."

As our mentors and the women upon whose shoulders we stand leave us, we remember with gratitude women like Edwina Froehlich and the six other mothers who began LaLeche League in suburban Chicago in 1956. We can all learn a lesson in marketing from the simple example of mother to mother dialogues. LaLeche League used attraction rather than promotion to raise breast feeding rates in the US from less than thirty percent in the 1950s to current rates of more than seventy percent.[11] Their approach was mother to mother, woman to woman, woman to doctor. Women wanted to know how to breastfeed and doctors at the time only knew how to recommend formula, so these women started coffee klatches and afternoon meetings, using the time to answer questions and fill a void.

Today we have the internet, Facebook, blogs, Childbirth Networks and even hospital childbirth classes as a place where women are seeking the real answers. After a natural birth or waterbirth, when women realize how amazing their unmedicated birth experience was compared to their first typical hospital birth, they will often ask the question, "why didn't anyone tell me this the first time?" We have a rare opportunity to take our accumulated knowledge of the physical, psychological, neurological, emotional and spiritual impact of pregnancy, birth and first year of development and use every available resource in helping shape a new quality of life on this planet. As Martin Luther King told us, "It is always the right time to do what is right."

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