# Andrea Vincent's Talk - Dec 2002

*** **The Pink Kit is now known as Birthing Better Childbirth Preparation**

## My message to you!

*'Don't knock that which you have chosen not to understand'*

I'm going to show you a few statistics that illustrate that Nelson Hospital doesn't yet have the answers to the growing caesarian rate. But rather than just rub it in, I will also give you a very simple way you can reduce those figures. There is no rocket science involved just common sense or common knowledge. In fact, it's embarrassingly simple that the obvious has been missed in medicine!

The Pink Kit; the body work; The Common Knowledge Trust – all one and the same. The programme that most of us have knocked at some stage ... for a zillion reasons. The main objection I hear repeatedly is that it is put together by someone with no formal training and hasn't been proven by research.

## Let's start addressing those concerns

It reminds me of the expression "a little bit of knowledge is dangerous" but then again, too much knowledge you drown in it and lose your way. Medicine is a bit like that and often serves to just increase fear and anxiety levels.

This information (Birthing Better) was put together by a woman who doesn't have any formal training in obstetrics ...she does have however 30 years of experience of birth.

And yes, we should be embarrassed that someone without any formal training could come along and teach us so much! Then again, we haven't been very receptive so far!

## The proof is in the pelvis

For those not familiar with the Pink Kit (which is most of you!). It is a self-learning kit for women and their support person, to become familiar with their own pelvic shape, identify what areas might obstruct labour, learn to effectively isolate individual muscles, and relax them, which also might impede progress.

Given that, what is to prove by research? From where I am standing – nothing! For the doctors among you, who worked on cadavers in your first year of med school, should have the best knowledge of the pelvic shape, and the muscles and ligaments attached to it and their function. Pelvis's are the shape they are, soft tissue does what it does.

To ask if the body work is researched is like asking for proof that the world is still round! The pelvis is what it is!

For the midwives here, who were also taught that anatomy and physiology, the mechanism of labour (until we could recite it backwards!), the management of labour. What was missing from all that was "how to birth". With experience, you pick some of it up along the way – but it's hit and miss.

I find it interesting talking to women who have had half a dozen children. Each labour they have picked up more of this knowledge by nutting it out themselves. But what a shame they have had to have six labours before they can call one labour good!

## Fear

- Fear is a natural part of any transition.
- Fear is dealt with by having personal knowledge and skills.
- Fear is healthy. It stops people from being naive, careless and foolish.

For modern women to be told all they have to do is surrender their fear of birth and all will be right has led to an increase in requested interventions by women, and the reaction of the care providers is to use more interventions.

It's called Fear of Pain, Fear of Death and Fear of litigation!

## Reviewing one's practice is a constant process.

I had always managed a normal delivery rate somewhere in the 80 percent – and I could live with that. In 2000 I had caesarian after caesarian forceps after ventouse – and that normal (unassisted delivery) rate dropped to 74%.

I was gutted – and I thank Kevin and Dave for kicking me when I was down – reminding me how often they were seeing me in the Caesar theatre.

It only served to remind me that I still do have some of the teenage rebellious streak left in me. You know the one that when the `grown ups' go one way, the teenagers take any opposite direction or view! They say revenge is sweet!

I took some comfort in the hospital rate being 63%.

Now if 63% push a baby out unassisted: 37 % don't.

37% of mothers and babies are therefore considered to be in danger of injury or death, that they require assistance?

At 37% surely that constitutes a health crisis?

Unless of course you believe that women's choice etc. etc. has had that much influence and then 37% is acceptable.

For midwives who believe themselves to be the "guardians of the normal" then 63% is called failing miserably!

## Screaming, shouting outcry?

In 2000, the climbing caesarian rate began a national outcry and it was then the Caesarian Audit Meetings were started in 2001.

I went to probably only one of those meetings and I stand by the same comment I made then sitting looking at notes, going *"we couldn't have avoided that one"*, or that one – doesn't change anything.

And no they probably couldn't have been avoided because the point in labour, where they were heading toward a caesarian probably was too late to do much.

There might be one or two C/S that with the benefit of hindsight could have been `sat' on longer.

What was obvious in the hospital as well as my statistics, was the biggest group in the C/S – forceps group were primps high head at term posterior positions – overdue – and when they get into labour go for the long grind .... you know the ones. They never used to happen in such large numbers – why do they now?

I figured 75% of babies would happen anyway, my target area was that next 10-15%, who frustrate us all when you know they should come out vaginally. So I decided the audit meetings weren't going to do it for me. I was convinced the change had to come antenatally – but how?

## Looking with a different eye

I had been at a couple of births where the CKT (**ed:** Common Knowledge Trust and Birthing Better) members were present and/or birthing. Initially I thought – *"Not a lot looks any different to how I practise"* – there wasn't a Hip Lift in sight!

What I realise now, is that there isn't anything to see because all the work is being done internally by the women.

What did strike me was the immense satisfaction those women had in their birth experience. They were buzzing!

There was probably an element of not being able to stand the thought that these women understood something I didn't.

And probably someone made the mistake of telling me not to go there – a sure reason for me to `go there', as I am one to always form my own opinion of people and events first hand thanks!

All that seemed a good enough reason to pick up the phone and call Wintergreen and ask her to teach us what she knew. But be gentle on us!!

## We started with weekly sessions

The Pink Kit also was up and running and saved me a lot of talking! (**ed:** First edition of Birthing Better/The Pink Kit was launched in 2000 with half the skills. Andrea did not start seriously working alongside CKT until 2002)

Passing on this knowledge was the only change I made to my practice and the results ...well you can judge for yourselves.

I nearly left 2001 out as it was mid-2001 that the impact of the skills started filtering through. And I noticed this trend.

The C/S rate halved – in other words babies were getting into the pelvis. But the forceps rate remained high i.e. they weren't getting out.

These babies were rotating because we went from Keilland's rotations to Neville-Barnes or Wrigley lift-outs.

The need for analgesia dropped – women just weren't asking for it. The augmentations lessened.

My conclusions to that were:

- Women were starting to look at the body work but certainly couldn't get their head around the internal work – then again nor could I!
- By not doing the internal work the women with tight birth canals either experienced delayed second stages or the baby became compromised and hence some of those lift-outs.

## Just get over it!

So, it became obvious I was going to have to have a major head shift myself in order to shift women with this internal work. When I thought about it, every month women insert and remove tampons. Women do NFP and can tell you what their cervix feels like. And the minute women are pregnant, they and we as practitioners accept that doing internals is `all part of the service'!

So why shouldn't a woman explore her own body? So just get over it!

I was giving the limited number of kits I had to women I thought most likely to end up with an assisted delivery.

Often it was the other women (**ed:** seeking or wanting a natural birth) who ended up with problems. Either I was picking them wrong or the kit was making a difference to the ones I

gave them to. So I doubled the number of kits! The point learned – this information is for all women.

Don't assume because they are up to baby number 8 that they keep coming back because they love labour! (Venessa's and Sue's story).

## 2002 (thru to the end of November)

By now 80% of these women had, had some exposure to the Pink Kit or the body work classes. (**ed:** CKT/Wintergreen taught classes for 3 years in Nelson. Every participant Edition #1 with half the skills. They were expected to self-learn while CKT/Wintergreen taught the rest of the skills that were added and became Edition #2)

But by this stage though I was seeing an incredible difference between those embracing the kit and those not.

In fact, I see a difference between those doing the body work classes, those who are self-learning from the kit and those not looking at it at all.

The smoothest labours are generally the body work classes group. (**ed:** Common Knowledge Trust does not train teachers or practitioners. The reason people in this group were so successful is that they were pushed and pushed and pushed to self-learn and Wintergreen filled in any gaps. **For those participating in the 2 year trial, they will learn how to work with families using Birthing Better skills)**

**The numbers now look like this:**

- The unassisted delivery rate went from 74% to being near 90%
- Nelson Hospital rates have gone from 63% to being 66%

Make ourselves feel better and take out the elective C/S and it leaves those that laboured.

My rate went from 74% to currently 96% of those who labour will push their babies out unassisted. Including one vaginal breech delivery.

Nelson hospital went from 60% to currently 73%.

That 73% could be shifted 5 if not 10% without even trying, by directing women to self-do the body work skills.

It should be mandatory for any woman wanting a trial of labour following C/S to have that information. (**ed:** This 2 year trial is NOT about Birthing Better. All skills should be offered. Women should choose. Do keep notes what resource each woman is using and what skills she self-learns. The purpose of this 2-year trial is grow skilled birthing families. Data collected after two years will show everyone what skills methods are the most effective and why. By making it normal and natural for pregnant families to self-learn birth and birth-coaching skills, hopefully there will be a rapid development of even more methods)

So long as the women have the (Birthing Better) skills it doesn't matter what practitioner is there and whether the midwife/obstetrician is familiar with the information. (**ed:** In the 2-year Trial every participant will notate what skills each woman/partner/other learn from 24 weeks onward. Any birth provider can refer back to those notes, praise and encourage.)

The one forceps delivery for the year back in January, for prolonged bradycardia, by the woman's own admission wouldn't have happened if she had done the internal work. Also knowing what I know now, no it wouldn't have happened and possibly the first C/S for failure to progress.

The other C/S was for fetal distress and in a primp with 17 years infertility and an IVF babe, I wasn't going to hang around to work out why we were getting huge decelerations.

I looked for other factors which may account for the change:

- Less primps, but note this year has slightly more primps than multips (not so for the hospital stats though)
- Bigger babies in 2000 – not so
- All three years the average baby weight was 3.4 kg. All three years had 8-10 babies over 4 kg. The electives/ non-labouring caesarians were:
- Breech x 3
- APH x 1 (in parity 7)
- Fetal distress/transverse lie/cord presentation/maternal food poisoning (in parity 8).

What we are seeing in the hospital rates is the expected rise in the elective C/S rate, with the change in caesaring all breech, and less forceps used. We could debate that one endlessly.

But if more babies can get further down into the pelvis and rotated, then you guys are obviously going to be more comfortable lifting babies out vaginally.

What would also help is if you were in the habit of assessing women while they are standing! It gives a whole new perspective on how those babies are coming into the pelvis and decent.

Skilled women also aren't asking for analgesia in the same numbers – relieve backache and tense soft tissue and the only pain remaining is the contractions – and they are manageable for a lot of women.

It is only those labours that drag on who are using epidurals. But less women who are having epidurals end up with an assisted delivery and /or augmentation.

This simple observation may well kill the argument that epidurals affect outcome. However with the lighter epidurals women will still hold that deep tension.

I stopped having problems with babies not rotating when I stopped rupturing membranes – and who was it that ever decided women should labour a centimetre an hour? So what if the heads stay higher until they are fully dilated – a bag of fore-waters will dilate a cervix if the head is nowhere to be found! And have you ever thought it might be the baby trying to tell us something?

I've had two high heads lately that I am sure if they had been lower in the pelvis, for the rest of the first stage, they would have been compromised, because they came out with the cords wrapped firmly around some part of their anatomy.

Women who do the internal work are less likely to sustain perineal damage and it keeps their babies safer! Bold statement I know, but one I have come to believe. Why? I can count on one hand the number of women who did the internal work (properly), who required any suturing.

Not one baby has had so much as a single dip in their heart rate in the second stage when the woman has done the internal massage. The same can't be said for the non-massage group. In that group, this year I had a baby that was the closest I have ever come to having a stillbirth in the second stage. There hadn't been a flicker in the heart-rate and no meconium until the last 3 minutes.

I was at the point of deciding to do an episiotomy because the head had sat on the perineum for a while. Once out it took 8 minutes to bag the baby around. Without prompting the mother said afterwards: *" that wouldn't have happened (the baby sitting there for so long) if I had done the internal work"* – she knew it!

If women need convincing to do the internal work I now tell them that story.

## I inspired mothers/fathers to reclaim birth

Which brings me to what else these women learn from these skills – *'Whose responsibility is it to get this baby out?'* If you were going to run a marathon for the first time or climb Everest .... Would you train for it or just figure your body should know what it is doing?

If birth is going to be re-claimed it will happen if birthing women become skilled at birthing... and that is learned and rarely instinctive.

Instinctive is often tension! Since labour can be very intense, often our instinctive response to the pain and intense situations is to draw back or tighten up.

Making choices of where and with whom to birth is not the same as bringing skills into your birth regardless of where and with whom you birth.

As a midwife, I have never had the ego to believe my presence is the `be all' or `end all' to a woman's birth (especially at 74%) ... It might offer a style or niceties or more freedom to do their own thing, but the outcomes starts and finishes with the women.

I know inspiring and insisting my clients become skilled has been a great gateway to instigate change in my practice. I am doing less work than I have ever done at births! And I am not there as long!

I rarely go home these days totally drained like I've felt every contraction – the woman does the labouring – not me!

I suffer less palpitations in the birth process.

Some primp births (**ed:** those who self-learned skills) recently I had to redefine 'normal progress' because I found myself being caught out by the speed at which some of these labours moved … from *"a little bit niggly"* to *"I want to push"*.

## What a relief

Life is so much easier for the women and for the three of us midwives who work together. I knew the relieving midwife at least had a common language of these skills and could get to the nitty gritty with the women in labour.

While it is all very nice for the LMC to be there, it is not such a big issue for these women because they know they have the skills to cope. It's not their midwife who is going to get that baby through that pelvis.

The partners love it – this is hands-on, mechanical boy's stuff and easily understood. It often brings couples closer when they have that shared understanding of their bodies. Above all else the guys like to feel needed and able to help their partners get their babies out. I haven't had a single epidural for partner distress all year!

As I was going over all these births again putting these statistics together, and I had to ask myself why bother putting these numbers together – because it isn't about statistics. They were put together for you: my sceptical colleagues!

It is all about the experience – the journey for those individuals.

- The women and their partners' ability to discover how-to birth well.
- To `connect' with their body and baby and aren't separated from the waist down, which is a large percentage of women today, for varying reasons.
- To be calm and generally in control in labour.
- To know where your baby is in the pelvis – to know when it is stuck but more importantly know how to shift it.
- And to know that your baby is OK – or not.

I have never had a year where when primps in particular so often say after they push their babies out: *"That was great"*. They usually quickly qualify it by saying *"It bloody hurt – but it was great"*

I am not deluded enough to think everyone of you will run out and buy a `Pink Kit' and embrace it, but I would like to at least see enough of a `head-shift' that individually and collectively there is acknowledgment: (**ed:** 15 years later, Common Knowledge Trust is making available this 2-year Trial)

- With a 66% normal delivery rate you don't have all the answers.
- Perhaps we have to go back to the basics and acknowledge the value of skills, no matter how experienced you think you are.
- To show tolerance and support for the women who wish to use the information – after all it is their experience not ours.
- If you have no interest in the concept that women should become skilled or the value of Birthing Better at least be humble enough to admit it to women rather than put down something you have no knowledge of.
- Iff you really are serious about shifting the C/S rate – consider scrapping the current antenatal classes which teach what is not normal – and for an 24 month trial, tender those classes out to the CKT to run. The savings made on the drop in C/S would probably pay for a decent birth pool in the new unit! And imagine if the Obstetricians were out of a job.