Research Update

Adopting Birth Philosophies to Guide Successful Birth Practices and Outcomes

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Abstract

Research studies conducted recently in hospitals located in Switzerland and Canada reveal the importance of birth philosophies in attaining successful birth practices and outcomes.

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The importance of philosophy in guiding birth practices is well accepted by Lamaze Certified Childbirth Educators. The research studies reviewed in this article point out the value of philosophy in changing birth practices and outcomes, as demonstrated in hospitals in Switzerland and Canada.

The first two papers, which complement each other, were published in the Swiss journal, *Fetal Diagnosis and Therapy* (Eberhard & Geissbuhler, 2000; Geissbuhler & Eberhard, 2000). In 1991, a new concept was introduced in the clinic of obstetrics and gynecology in Cantonal Hospital, Frauenfeld, Switzerland. The main themes of this new concept are similar to the Lamaze philosophy and include careful monitoring and birth management, restrictive use of invasive methods, promotion of the natural birth process, and participation of the parents in decision-making during labor and birth, including the free choice of birth method. Eberhard and Geissbuhler (2000) subsequently compared the mother's choice of birth method in spontaneous cephalic single births in three groups of parturients. The first group provided an historical context and consisted of 5,602 women who birthed in their own clinic from 1986–1990. The second group of 9,418 women gave birth in the same clinic from

1991–1997 after implementation of the new concept. For outcomes, a third comparison group consisted of 344,328 women who birthed in other Swiss clinics between 1986 and 1997.

Prior to the introduction of the new concept, 99.8% of the births at the Frauenfeld clinic were bedbirths. By 1996, bedbirths dropped to 29.8% but subsequently rose to 44.1% in 1997. Use of a Maia-birthing stool for births increased to 23.3% in 1993 but dropped to 9.6% by 1997. Waterbirths have been the most frequently chosen alternative, accounting for more than 30% of births in 1993 and 1994 and more than 40% of births since 1995. Other methods—including standing, sitting, holding a rope, employing “all fours,” and using the Roma wheel—were available but rarely chosen.

Waterbirths have been the most frequently chosen alternative, accounting for more than 30% of births in 1993 and 1994 and more than 40% of births since 1995.

Outcomes have been compared. Cesarean birth rates were slightly higher in 1998 (12.0%) in comparison to historic rates in 1990 (9.7%) but lower than those of other Swiss clinics (15.5%) in 1997. (In comparison, the cesarean rate in the United States was 22% in 1999.) Thus, the rise in cesarean rates could be classified as less than expected in that time frame. Episiotomies declined from 61.7% in the historical group to 13.1% in the new concept group; the episiotomy rate for other Swiss clinics was 47.1%. Epidural rates (low in comparison to the United States) were 11.4% in the historical group, 14.7% in the new concept group, and 23.8% in the other clinics.

In a companion paper in the same journal, Geissbuhler and Eberhard (2000) examined outcomes for waterbirths and bedbirths. The cesarean birth rate was slightly lower for waterbirths (13.1%) compared to bedbirths (15.5%). The greatest difference was in episiotomy rates: 13.1% for waterbirths compared to 47.1% for bedbirths. Total epidural rates (vaginal and cesarean births) were 14.7% in the waterbirth group and 23.8% in the bedbirth group. No differences existed in fre-

quency of induction, use of oxytocin for labor stimulation, and amniotomy rates.

A third study demonstrating the importance of philosophy comes from the Ontario Women's Health Council in Canada. The women's health council advises the Ontario Ministry of Health and Long-Term Care. In their report, *Attaining and Maintaining Best Practices in the Use of Cesarean Sections* (Ontario Women's Health Council, 2000), the authors state that “hospitals with low cesarean section rates have achieved this goal by embracing the belief that supportive labour care and the least intervention possible create the best opportunity for a good birth experience” (p. 2). The study was prompted, at least in part, by rising rates of cesarean births from 17.3% in 1993 to 19% in 1998. Average provincial rates range from 16% in Saskatchewan to 22% in British Columbia and Newfoundland. (As in Switzerland, this overall rate was lower than in the United States.)

Critical success factors in lower cesarean rates were attitude toward childbirth, organization of care, knowledge and information, coordination and networking, and the ability to manage change. The four hospitals in this study were proud of their low cesarean rates (ranging from 12.2% to 17.4%), viewed childbirth as a normal physiologic process, and were committed to one-to-one supportive nursing care during active labor. A hospital-wide commitment to lowering cesarean rates was evident among all staff members, from the chief executive officer on down. They had effective multidisciplinary teams with strong team leadership, a strong commitment to evidence-based practice, continuous quality improvement programs, and an accessible and interactive database. Staff developed networks with peers and organizations in order to stay up-to-date, share information, and avoid isolation. Coordination with other ma-

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ternal/newborn services was enacted in order to assure continuity of care. Change was recognized as the norm in health care today, and staff members were willing to monitor their performance and adjust their strategies to continue to attain their goals through times of significant change. In spite of declining budgets, the hospitals were able to maintain the one-to-one labor support recommended by the Society of Obstetricians and Gynecologists of Canada (Ontario Women's Health Council, 2000).

In the United States, the lack of progress during labor is a dominant reason for cesarean delivery. In a fourth study, Gifford and her colleagues (2000) examined lack of progress in labor as a reason for cesarean. They reviewed medical records and conducted telephone interviews with 733 women who delivered by cesarean. The authors note that the American College of Obstetricians and Gynecologists (ACOG) published a document in 1994, *Quality Assessment and Improvements in Obstetrics and Gynecology*, in which guidelines for proceeding to cesarean delivery for lack of progress in labor were reiterated from several previous publications. The authors found that "at least 16% of the subjects who had cesareans for lack of progress were in the latent phase of labor according to ACOG criteria. The second stage was not prolonged in 36% of the women who delivered by cesarean at 10 cm." (p. 589). Neither of these practices conforms to published ACOG diagnostic criteria and, thus, appear to act from a philosophy that does not promote natural birth and does not restrict use of invasive methods as espoused by the Cantonal Hospital in Switzerland.

Comparison of birth philosophies and outcomes from

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varying countries is useful in raising questions about the efficacy of particular birth practices. It is worth exploring whether or not the adoption of philosophical perspectives, which are apparent in the Swiss and Canadian studies, would make a positive difference in birth outcomes in the United States.

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Taking Charge of One's Life

They always say that time changes things, but you actually have to change them yourself.

—Andy Warhol

Blessed is he who has found his work; let him ask no other blessedness.

—Thomas Carlyle