The Dance of Advocacy

Judith A. Lothian, PhD, RN, LCCE, FACCE

ABSTRACT

A childbirth educator asks how she can continue to use best evidence and prepare women adequately for birth within the constraints of a hospital practice that pressures educators not to “rock the boat.” This column discusses the challenge of advocating for normal birth and the dangers inherent in the advocacy role. Advocacy requires the childbirth educator to “dance” with many partners, including physicians and hospitals. Strategies for inviting colleagues and class participants onto the dance floor and teaching them the steps of the dance are explored. Guidelines for reducing risk and engaging women are discussed.

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READER'S QUESTION

I teach childbirth education classes in a large hospital. We use a curriculum that appears consistent with the Lamaze goals of increasing women's confidence and promoting, protecting, and supporting normal birth. The reality, however, is that many of the hospital practices do not promote, protect, and support normal birth. There is pressure from physicians, anesthesiologists, and even the director of the childbirth education program (at times) not to “rock the boat.” For instance, after showing a video that highlights the negative effects of medication and the mother's separation on her baby's ability to crawl to the breast and self attach, I was told that anesthesiologists did not like the video and to stop showing it. I cannot use the birth ball in class because, although the hospital does not have an official policy, the nurses think it is unsafe. How can I continue to use best evidence and pre-

pare women adequately for labor and birth within the constraints of my hospital?

COLUMNIST'S REPLY

Childbirth educators everywhere face similar challenges. You raise two quite distinct but interwoven issues: the challenge of presenting “best evidence” in childbirth education classes and the dangers inherent in being an advocate for normal birth in the complex world of modern obstetrics. It is not enough to know the evidence and share that information with women. Childbirth educators need to teach in ways that advance their goals and, at the same time, reduce the risks of being “shut out” by the women they teach or “shut down” by the powerful medical establishment.

An analogy might help. Think of advocacy as a dance. “Best evidence” is the music. Like a country reel, in the dance of advocacy for normal birth,

everyone on the dance floor is the childbirth educator's partner—the women and families you teach, physicians, midwives, nurses, hospital administrators, and the larger society. This is not a dance that is danced alone! And, like any dance, knowing some steps and getting to know your partners are important as participants find their rhythm, ultimately moving effortlessly in time with the music. Depending on where childbirth educators teach and who they teach, at different times they will find themselves leading the dance, encouraging the women they teach to lead, and—more often than not—being dance instructors for their colleagues. There can be no “dancing around” the issues childbirth educators face or sitting on the sidelines waiting to be “asked to dance.” A dancing lesson in advocacy might be as simple as the steps described below.

Know the Music

The evidence in support of normal birth is substantial and widely available. The gold standard is The Cochrane Library, the repository of systematic reviews and best evidence from around the world. Abstracts are available online (www.cochrane.org). Additionally, the full text of *A Guide to Effective Care in Pregnancy and Childbirth* (Enkin et al., 2000)—a summary of the Cochrane research, with recommendations for practice—is available online (www.maternitywise.org).

The Maternity Center Association's (MCA) Web site is another excellent resource for evidence-based information (www.maternitywise.org). On the site, you will find the report of the *Listening to Mothers* survey (Declercq, Sakala, Corry, Applebaum, & Risher, 2002) and *What Every Pregnant Woman Should Know About the Risks of Cesarean Section* (MCA, 2004). MCA is currently working on a systematic review of the risks of induction.

The Lamaze Institute for Normal Birth was launched in 2003 with the goal of being a resource for promoting, protecting, and supporting normal birth. Six care practice position papers, written for the consumer but equally valuable to the professional, are available at the institute's Web site (www.lamaze.org/institute/). Ongoing research updates are just one feature of this cutting-edge Web site.

Lamaze Parents Magazine (the only prenatal magazine that abides by the World Health Organization's guidelines for the marketing of infant formula) and *Giving Birth with Confidence: The Official*

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Lamaze Guide (Lothian & De Vries, in press) reflect best evidence and the Lamaze philosophy of birth. They also provide a foundation for helping women begin to think about birth in a different way—that is, moving beyond believing birth is fraught with danger to trusting in their own ability to give birth. Knowing the music has never been easier.

Play the Music Frequently

Best evidence should be our mantra, not just in our classes but in our interactions with colleagues. Pass on the Lamaze care practice position papers. Distribute copies of the latest research updates posted by the Lamaze Institute for Normal Birth. Talk about what you are learning while at lunch, over coffee, or waiting for the elevator. In doing so, you are gently and confidently inviting your colleagues onto the dance floor. If they resist, confidently persuade—showing, not telling—them to join you. Teaching the music takes time and patience.

Joan Harper has been a childbirth educator for many years at St. John's Mercy Medical Center in St. Louis, Missouri. With childbirth educator Gloria Newman and labor and delivery head nurse Liz Phillips, Harper brought the Lamaze Labor Support Specialist Program to their hospital. It took a long time to get it off the ground, but ultimately over 128 nurses completed the program over a five-day period. The nurses left the one-day workshop eager to incorporate what they learned into their practices. And they did. Debby Amis and Jeanne Greene taught the programs, returning one year later for a refresher course. At that time, the nurses reported that the tubs had been taken out of the utility closets and were being used. That week, two water births had taken place!

Over and over again, present best-evidence material in your classes regardless of what the hospital policies are (keep in mind that “policy” is not always evident in practice, and that “no policy” is often a powerful asset). Best evidence must always be the foundation of your practice, and using best evidence is excellent protection when it comes to

A Guide to Effective Care in Pregnancy and Childbirth (Enkin et al.) and many other helpful publications are available at the Lamaze Bookstore and Media Center (www.lamaze.org).

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reducing the risks inherent in your advocacy role. An equally important protection is your commitment to helping women make truly informed decisions. How you deliver the best-evidence message and how you help women make informed decisions is critical. This is where it is easy to step on toes, lose your rhythm, and send your partners flying off the dance floor. Learning a few steps and practicing them are important.

Learn and Practice the Steps

Here, it gets tricky. As in learning any new skill, practice and patience—with yourself and your dance partners—are required. In your teaching, you are in a very real sense role modeling for the women in your classes. You help your students learn the steps of the dance by teaching how the system works and encouraging them to learn how to most effectively communicate and negotiate within that system. One cannot learn to dance by simply listening to a lecture. Your teaching should not be telling; rather, it should be *doing*. Teaching the steps involves demonstrating your own ability to communicate and negotiate appropriately and effectively. Next, you can provide the opportunity for your students to practice communication and negotiation, first in your class and then with their health-care provider, the nurses who will care for them, and the hospital.

For you and the women you teach, the prelude to getting started is understanding the big picture: who is doing what steps and why. That is why spending time on the history of birth and the complexities of the current system of birth is so important. This understanding provides direction for childbirth educators' communication and, ultimately, the negotiation that is an integral part of advocacy. Judith Rook's (1997) *The History of Midwifery and Birth in the United States* is an amazing resource for all aspects of the history not just of midwifery but of birth in the U.S. Sheila Kitzinger's (2000) *Rediscovering Birth* is a beautiful story of the history of birth across cultures. Kitzinger is a role

model for presenting best evidence in a way that is strong and honest while, at the same time, gentle and nonconfrontational. She carefully shapes her telling of the story of birth in ways that keep women—and childbirth educators—reading.

The difference in the way midwives and physicians think about birth is, of course, at the heart of the problems childbirth educators face and accounts for many of the missteps on both sides in the dance of advocacy. Childbirth educators need to do a better job of confidently articulating their beliefs and vision in ways that are not combative. Respect, not anger, must inform our communication, especially when we disagree. We need to take the lead in the dance—gently and persistently leading our colleagues and the women we teach—without stepping on their toes or forcing them off the dance floor. In and outside of class, childbirth educators must shape the information in ways women and colleagues can process, not dismiss. Aggressive, angry communication never moves anyone forward. For most women, if it is a choice between what the doctor says and what childbirth educators say, the doctor wins. You can avoid that situation if you do not allow it to come down to “us” and “them.” Remember that country reel—everyone's your partner—whether you teach in or outside the hospital. So, physicians and hospitals can never be ignored.

For example, you encourage the women in your classes to choose normal birth, and you help them develop birth plans that promote, protect, and support normal birth. But their dance partners include physicians and a hospital with restrictive practices. You may be tempted to tell these women, “You will never have a normal birth with your doctor in this hospital,” but you resist the temptation. Relating such a statement sets the stage for losing your job and having women walk off the dance floor. You will need to help women see the challenges they will meet and develop strategies for maximizing the chances of being able to have the births they want. Know the hospital policies. Know the evidence. Let women know that confidence, freedom, and support are hard to grab and even harder to hold onto in many hospitals. Then, help them develop a plan that might include staying out of the hospital for most of their labor. Let them know how a doula can help them feel safe and confident in early labor at home and in the hospital. For most women who give birth in a typical large hospital, the dance involves small steps in a confined space; but

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gradually, as change happens, dancing can be more open, free, and rhythmic.

At the same time the women in your class become confident advocates for themselves, you must advocate for normal birth in the larger system. Getting to know individuals in important (and powerful) positions—such as the director of maternal/child nursing, a family practice physician, a sympathetic obstetrician, or a good midwife—and having them get to know you can set the stage for establishing collaboration and making changes. There is no limit to the power that comes from being known and respected as a childbirth educator who is knowledgeable and persistent.

Sometimes (or too often in some places), the music plays, the invitation is extended, the steps are learned and practiced, and no one joins you on the dance floor. What then? It might be time to consider dancing somewhere else. For the childbirth educator, it means finding another venue for teaching. For class participants, it might mean changing health-care providers and/or the place of birth.

I once heard a labor nurse say, “If she wants a water birth and no routine interventions, she has come to the wrong hospital. No matter how much communicating and negotiating, it’s not going to happen for her in this hospital at this point in time.” I was taken aback, and then I listened. She was terribly upset that the women who come with “unattainable” birth plans have not been told ahead of time about the lack of “fit.” I was stunned when the nurse said, “I dread having a woman who does not want an epidural because I know I don’t have the time to give her what she needs.”

Many childbirth educators worry about the dilemma that ensues when it becomes clear that what a woman wants is unrealistic within the constraints of the hospital and the physician she has chosen. I suggest it is a dilemma for the women we teach, not for us. We need to be honest and to shape discussions so women can truly understand their realistic choices and the implications of those choices on their labor and birth.

Additionally, I do not think we can assume that most women late in pregnancy are completely happy with their doctors or that they trust them implicitly. Therefore, it is not unreasonable to present changing health-care providers or the place of birth as options to be considered. The most important thing we can do is help women face the dilemma and untangle the implications of alternative deci-

sions, including changing health-care providers and/or the place of birth. Can we do this while teaching at the “bad-fit” hospital? I think we can. But we need to be respectful, measured, and reasonable in our teaching and our discussions.

I regularly engage in impatient (even angry) discussions with friends, family, and like-minded colleagues about specific hospitals and providers whose care is not evidence-based. But when I speak at grand rounds, or teach a woman who is a patient of one of those physicians, or present a continuing education program at one of those hospitals, you can be sure that I honestly present the evidence—and I do so respectfully and methodically, gently presenting a different way of thinking and doing. Our goal is to persuade not alienate.

CONCLUSION

Childbirth educators everywhere face the same challenges. If normal birth is to become the standard once again, we all need to step onto the dance floor. “Sitting out” is not an option. Nor is dancing alone. Persuading women, our colleagues, and the larger world of modern obstetrics to join the dance will require practice and patience. We gotta dance!

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JUDITH LOTHIAN is a childbirth educator in Brooklyn, New York, and a member of Lamaze International Board of Directors. She is also an associate professor in the College of Nursing at Seton Hall University in South Orange, New Jersey.