Teaching and Learning Birth: “Help All to Know”

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ABSTRACT

This guest editorial explores the idea that our worldview, regardless of education, influences our childbirth practices, sometimes interfering with achieving the goals of our discipline. Over time, we have lost our ability to support women through the process of childbirth so that they emerge as strong, healthy women. The high road ahead is to teach everyone, including ourselves, that we need to provide optimal, evidence-based care. Pursuing this path will take courage and commitment.

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The Journal of Perinatal Education, as the official publication of Lamaze International, provides our discipline with the latest scientific evidence and resources to enhance childbearing care. The mission of Lamaze (2010) is “to promote, support, and protect natural, safe, and healthy birth through education and advocacy through the dedicated efforts of professional childbirth educators, providers, and parents” (para. 3). This mission is particularly important in the current health-care arena where few women are afforded support in their innate capacity to birth.

What “matters” in birth is complex, extremely hard to quantify, and will vary from one person to the next. In preparing to write this guest editorial,

I found myself contemplating what mattered most in my ability to support women in birth so they could emerge from the process as strong, healthy mothers. I believe we have collectively lost our way over time about this outcome—the strong mother. The mother’s experience of childbearing, which will affect her forever, can directly influence her future as a mother. How do we address this as a *discipline*?

I specifically italicized *discipline* to highlight a point about how we come to understand and see birth. The *Oxford English Dictionary* (2010) defines discipline as “a branch of instruction or education; a department of learning or knowledge; a science or art” Every one of us involved in childbearing, including women bearing the children, nurses, midwives, physicians, doulas, childbirth educators, and families, brings a worldview about the knowledge we call childbirth. Much of that is culturally defined—even those with formal education in childbirth are socialized by what is taught about roles, expectations of the process, and what outcomes are valued.

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It is human nature to hold steadfastly to long-held beliefs; the imprinting of our early learning is extremely hard to erase. However, there are times when beliefs can be toppled. I believe we are on that cusp in childbirth today. Despite spending more money on health care than any other nation, we have abysmal infant mortality outcomes compared to our global counterparts. More than one-third of women will have a surgical birth, and we are beginning to experience a rise in maternal mortality. Women who have been so traumatized by birth are choosing to “go it alone” to prevent anyone from interfering with the process. What a sad and sobering place we find ourselves, and it is time for change.

All of us want the best outcomes from childbirth. How we define those outcomes will differ based on our worldview. As a critical care nurse before I became a midwife, I tended to measure my worth in “doing”; there was always a lot to be done and to document in a shift. I did learn to sit with those who were worried, scared, and facing death, but so often, the “busyness” of my work prevented this kind of care. When I began to observe midwives, I had to readjust my thinking about what they “did” as they cared for women. During my midwifery education, I had to purposively step back from my worldview and learn this different way. My critical care skills of observation served me well, but I had to change the lens from one of illness to wellness. I learned to trust women’s bodies to birth, that suffering was different from pain, the importance of the birth setting, and the value of vigilant presence. I learned how to apply the evidence we know and to carefully assess how my actions might affect the childbearing process. Eventually, I learned to replace fear with trust in women and my skilled observations. Finally, I saw the magic of infants that start life received into their mothers’ strong hands, alert, and actively engaged with their world. They were valuable lessons, both as a provider and as a team player.

I believe every one of us has the responsibility to teach our discipline to everyone we can—and that starts with teaching ourselves first. The evidence is clear that women have better outcomes when we intervene only when needed. We need to personalize our care to every woman based on her needs, her

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desires, and her state of health. We must hone our skills in teaching women and their families to understand the value of birth and its long-lasting effects for the woman, the infant, and the family. Moreover, we must provide birth settings that are safe, whether in the hospital, birth center, or at home. This includes, but is not limited to, providing continuous support in labor, allowing women the freedom to move and assume positions of choice, using intermittent auscultation, offering nourishment of the woman’s body and spirit, using nonpharmacologic pain relief modalities whenever possible, and ensuring seamless, collaborative teamwork.

All of this takes skill, but more importantly, it requires courage. It takes creativity and gumption to convince nursing and medical staffs to eliminate admission monitor strips in favor of intermittent auscultation and to forgo routine intravenous placement. It takes time and commitment to explain to a woman why, in most cases, she and her baby will be served best by waiting for labor to start on its own. The high road ahead is to provide optimal, evidence-based care. If you are reading this journal and guest editorial, then you have taken the first step to making a difference for women and families through our discipline—do it, write about it, and teach it in every venue possible to help all know the lifelong value of birth.

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