A CONSUMER VIEWPOINT

Looking for an Obstetrical Caregiver in the United States: One Woman's Experience

Alison Barrows Ronn

When I first found I was pregnant, I asked a friend if she could recommend a doctor and I made an appointment. I had not done much reading before my first appointment, but I did have a general idea of what I wanted—as intervention-free a birth as I could handle. I wanted to be able to look back on the birth and say, ''That was really hard, but I did it!''

I had my first appointment when I was two months' pregnant. My first contact at the obstetric practice was a brusque woman whose title I never caught. She took me through a bunch of material, for instance, asking me if I was going to have the AFP (alpha-fetoprotein) test and if I was going to breastfeed, but she did not educate me about my choices. I was discouraged at the lack of information and guidance.

On the same visit I found I liked the obstetrician that my friend had recommended. We did not discuss many issues, but I did have some questions. When I asked her about positions for childbirth, she said I could try other positions, but that most women gave birth on their backs, and this was the easiest position for the doctor to deliver the baby. From what I had read, this is the worst position for most delivering women. Obviously I was not going to be encouraged to find an alternative position to give birth that worked for me.

During the next few months of my pregnancy I read a lot and thought about the kind of care I would like to have. Much of what I read, even in the up-to-date pregnancy and nursing books, made me angry. It seemed that many procedures which have been proved ineffective in most cases are still used, and that many which have been proved effective are not used. For instance, routine episiotomies, augmenting labor with Pitocin, constant electronic fetal monitoring, and feeding on a schedule are all still common, whereas encouraging movement and changes of position (including for delivery), providing support and comfort for the laboring mother, and use of bathtubs or Jacuzzis and other nonpharmacological methods of pain management are not.

And I heard enough from friends who had recently delivered to make me believe that these ineffective practices occurred in our local hospitals. For instance, although one friend had decided to breastfeed, her baby was given a bottle in the nursery in the middle of the night. Perhaps she would have had problems anyway, but she ended up pumping and bottle-feeding for about a week before the baby would successfully nurse.

Another friend had arrived at the hospital 7 cm dilated—she said she thought she was home free. When she arrived, the labor and delivery nurses strapped an electronic fetal monitor on her and never took it off. Consequently, she was stuck in bed for the duration of her labor and in retrospect wished she and her husband had been better prepared to assert themselves. All the reading I have done so far indicates that continuous electronic fetal monitoring can be uncomfortable for the laboring mother, and that in low-risk births does not lead to better outcomes and may, in fact, lead to unnecessary interventions. It also focuses attention on the machine rather than on the laboring mother.

I began to worry about a ''routine'' delivery at our local, highly recommended hospital. My reading had made me believe that my best chance for a birth with few or no interventions was to be well supported and

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The first part of this paper is modified from an article in the Massachusetts Friends of Midwives Report, Fall, 1999, and was written when she and her husband were awaiting the birth of their first baby. Their son, Parker, was born at the BirthPlace in Wellesley, Massachusetts, on 9 November, 1999.

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well coached. I wanted to have someone with me who was working to make me comfortable and had a great deal of experience to draw on. However, I was beginning to be afraid that I would not find the support I wanted at the hospital. In fact, I began to think I might feel antagonistic toward policies I encountered there. To have the best chance at a natural birth, I wanted to feel relaxed and supported during my labor, and not be fighting the hospital system or expecting my husband to do so.

In my fourth month I began to look into birthing with a midwife—someone who was trained to see pregnancy and birth as a natural process rather than as a problem to be treated. But I found that midwives no longer attend births at our local hospital. I remembered reading about these cutbacks—little did I know they would affect me so soon!

I considered hiring an experienced doula who could provide support and coaching. However, a doula would have no authority in the hospital, so we still might end up arguing with hospital policies, which would not help my labor at all.

I continued looking into options and found a free-standing birth center about 35 miles from our house, where I could give birth in a homelike setting with a midwife in attendance and lots of support for natural pain management, including a Jacuzzi tub. I decided to change caregivers with the goal of having my baby at the birth center. If I have any risk factors, I will have my baby at the hospital near the birth center with a midwife in attendance.

If our local hospital had midwives, I think I would have my baby there. I would want to be at this hospital if anything went wrong with the delivery, or if the baby had any problems. But I have to plan for a normal birth—I am low risk, and most births do happen without serious complications. Also, I feel far more confident that the midwives at the birth center will help me and support me through a normal labor and birth and that their support will minimize my chances of needing medical intervention and the complications that can occur with interventions. I regret having to give up the convenience (our local hospital is 10 minutes away—the birth center is 40) and the medical excellence at our local hospital, but I strongly believe that for a low-risk birth where the parents want minimal medical intervention, midwife attendance is the right choice.

Postscript

Parker was born on 9 November, 1999, at 5:12 AM. He was 9 pounds 7 ounces. His birth was intervention free. I arrived at the birth center about three hours before he was born, used the Jacuzzi, and was coached through changes of position before giving birth in a queen-sized bed. Parker never left the room I was in, and nursed within an hour after birth.

The sources I have read say that women have better births when they are confident and supported. My birth environment provided that for me. I was confident that my caregivers would not suggest unnecessary interventions, yet I was also confident that they would take the best care possible of my baby and me. And whether because of that, or just because I was lucky, I had a relatively quick and easy birth.

I would like to see more practitioners approach prenatal care as a partnership. Usually, no one cares more about the health of the baby than the pregnant woman and her partner. A doctor or midwife can offer expertise and even opinions on care and procedures during pregnancy, labor, and delivery, while leaving most decisions up to the expectant parents. In addition, when the practitioner understands that there are different approaches to prenatal care, it would allow the practitioner to present his or her approach honestly, and allow the pregnant women to choose the practitioner and the approach that most closely matches her own.

At the same time, it is important to offer real education about tests and procedures that may be used during pregnancy, labor, and delivery. This includes a clear explanation of any negatives in addition to the positives. Including opinions can certainly be useful when the woman is trying to make a decision. If she has chosen a practitioner with an approach that she desires, an opinion can be extra guidance—especially when it is clear that it is an opinion. There seems to be an assumption that women know about the pros and cons of tests and procedures already, but I think that is the exception rather than the rule.

I would like prenatal practitioners to offer information on the benefits of a low-intervention birth, including the physical benefits to the baby and the emotional benefits to the mother. Parenting is a hard job. What better way to start than knowing you did your best in probably the hardest physical task of your life, and that in that personal success you also did the best for your baby?

I think it is important to offer education about the benefits of breastfeeding to mother and baby. I think many practitioners believe that women already know about it, or they are eager to offer women the choice between formula and breastfeeding. Facts can be provided about breastfeeding as they are about any medical procedure, without pushing a decision one way or another.

Although some interventions are clearly necessary and can save lives, many practitioners seem to have a mindset that interventions equal success because they

allow you to care for the laboring woman. A laboring woman can be cared for without medical interventions. Instead, they should offer support and coaching based on solid experience with labor and birth—experience that most laboring women and their husbands or partners lack.

I searched for the care that was right for me, and I had a good birth. However, I did not find everything I wanted in one place—I had to make compromises, and I had to look hard to find what I wanted. Perhaps by the time I am ready to have another baby, finding the care I want will be a little easier.