

Utilising the Unborn Baby's In-Labour Movements

Aspects of midwifery practice, just as in obstetrics, can be validated in the absence of quality evidence simply because many repeat a certain action. Listening to the unborn baby's heart rate every 15-30 minutes in labour and after every contraction when the woman is pushing is one such practice.¹ However good the intent is to counter intervention-inducing Electronic Foetal Monitoring (EFM), it has developed the authority of a prescribed practice – not because it has shown to be of benefit but because it is has been acknowledged as a common midwifery practice.

Those who are familiar with an undisturbed labour scene acknowledge that lack of stimulation enables the primitive brain to help the woman to be 'on another planet'. Any stimulus to the neo-cortex of the brain makes the labouring woman more alert, and can inhibit her labour², thus intellectual stimulation is to be avoided. While intermittent auscultation is less invasive to the woman's 'birthing head' than EFM, any disturbance to the woman in labour has the potential to interrupt physiological birthing. It becomes imperative to consider other ways to assess and monitor the unborn baby and to utilise what exists in the physiological labour state.

As I discuss in *Home birth bound: mending the broken weave*³, the unborn baby has distinct behavioural states in pregnancy. I have observed over many years of home birth practice that the majority of unborn, well babies continue to move throughout the labours of their well mothers. Reflection on this knowledge and how it can be utilised has resulted in a change within my practice from listening to the unborn baby's heart rate at prescribed intervals to incorporating movements into the assessment of the baby's well being in labour.

There are three aspects of 'known' that are important for this method of monitoring:

1. The known midwife, as occurs with continuity of care throughout the childbearing continuum;
2. The known environment, as in home birth; and,
3. Known movements by the woman of her unborn baby.

While, for the purpose of this paper, the first two 'knowns' will be presumed to exist, the third is discussed.

An awareness of the known pattern of the baby's movements is initiated when movements are first reported in pregnancy. The importance of the woman monitoring her baby's movements is affirmed and recognition of any pattern is nurtured. Any pattern that has established over time becomes her baby's norm. Kick Charts are not used - not only because of the false sense of security that may be created by dismissing a change in a pattern outside the allotted time frame, but also, because the interpretation of the Kick Chart is done by the health professional and therefore can invalidate the woman's own knowledge. Thus the woman's own knowledge remains central to assessment.

Assessing the baby's well being with in-labour movements is discussed with the woman in late pregnancy. The knowledge of this process helps her to participate and a frequent spontaneous acknowledgement of baby's in-labour movements is for the woman to report, "moving" or "kick".

Rolling movements and limb kicks can be visualised by the midwife in the pool, especially where millpond stillness

gives way to shimmering with the baby's movements. Movements can be felt through comforting hot cloths on the abdomen and back. Those movements felt through the perineal hot packs are most likely to be those of the baby descending rather than specific baby in-labour movements.

At times it remains necessary to ask the woman if the baby has moved in the last few minutes. Where there have been no further movements since the last noting, a common response to this question is for the baby to move, in the same way that discussion about the baby in the antenatal period often invokes movements. This invasion of her 'birthing head' is minimal in comparison to asking her to shift her position so the baby can be listened to. Where recent movement has not been sensed, wherever possible, the Pinard or Allen Foetoscope is used to avoid unnecessary ultrasound exposure via a handheld Doppler.

It is doubtful if baby's in-labour movements monitoring would be valid where physiological labour has been interrupted by artificial rupture of membranes, Induction of Labour and Nitrous Oxide, narcotics and/or epidural anaesthesia use – the latter three measures affecting the woman's innate connection with her baby. It is also unknown whether it would be a valuable adjunct for the unfamiliar environments of birthing units. It is of limited value for those few women who do not readily sense their babies' movements, in breech presentation where the movements of the legs and bottom - the commonest 'moving parts' – may be restricted, or in multiple pregnancies where the individual baby's movements may be difficult to differentiate from that of his sibling.

Knowing how important the reclamation of midwifery knowledge is, the researcher in me urges auscultation of the baby's heart rate after in-labour movements to gather 'hard evidence' that this sign of well being equates in labour equally as it does in pregnancy. However, my commitment to not disturbing a physiological state prevents this action from taking place. Just as I trust the woman's reporting of movements so I also trust the development of my practice wisdom.

This method of assessment is a useful tool to minimize stimulation. Monitoring of the unborn baby's in-labour movements has become integral to the care I provide in labour to well women and has proved to be highly acceptable to and welcomed by women in my home birth practice.

References

- 1 Maternal and Newborn Health/Safe Motherhood Unit, World Health Organisation. (1996). *Care in Normal Birth: A Practical Guide*. World Health Organisation: Geneva. P.17
- 2 Odent, M. (1999). *The Scientification of Love*. London: Free Association Books. Pp.28-30.
- 3 Banks, M. (2000). *Home Birth Bound: Mending the Broken Weave*. Hamilton: Birthspirit Books. Pp.98-100.

Citation Reference

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