Stepping Stones and Cervical Wisdom

By Sara Wickham
RM, PhD, MA, PGCert, BA(Hons)

Watching, listening to and talking with women, and each other, grows our understanding of the diversity that makes up women's experiences of childbirth. In this article, how individual women's cervixes 'behave' in labour is used to illustrate the process of increasing midwifery knowledge.

If an alien visitor to the Earth took mainstream midwifery and medical textbooks to be her only source of information about childbirth, she might get the impression that the cervix was a rather unadventurous and linear part of a woman's body. Opening in a unidirectional manner at a relatively steady pace, the labouring cervix is generally portrayed as being a tube which shortens to become a circular hole through which the baby emerges in the manner of someone pulling on a polo-necked jumper. The cervix may occasionally be deemed to be a bit naughty (for example by opening too early, too late or too slowly), but it is not always presented as being one of the most exciting or interesting elements of labour and birth.

Invite the alien to spend any amount of time with pregnant or labouring women, though, and as long as her eyes and mind are relatively open, her perception will almost certainly change. It will change because each birth she attends has the potential to act as a stepping stone towards a fuller understanding of the complexity of the behaviour of women's bodies in general and the cervix in particular. Give her a few of the articles and research papers that midwives have written over the past few years on this topic and she will be able to tread even more of the stepping stones which are leading us to a better understanding of what I once described as the "somewhat mysterious, marvellously erratic and essentially unpredictable" behaviour of the cervix.[1]

This article is a somewhat random collection of some of the stepping stones that I have trodden on my way to learning more about the cervix, with the help of birthing women, other midwives and researchers. It is not intended to be the definitive collection, not least because we all have different experiences, and one midwife's latest insight might be something that another midwife has always known. (Indeed, it would be impossible to produce a definitive collection, because there is always so much more we can learn.) It begins by acknowledging the woman whose story provided one of the early stepping stones on my own journey to understanding a bit more about women and their cervices.

Saskia's Story

I first got to know Saskia when we were both midwifery students in different parts of the UK. Saskia was (and remains) a feisty woman who didn't care much for rules or convention, which might partly explain why she eschewed relying on the standard route (at least in her University) of perfecting the skill of vaginal examinations by performing lots of them, after her midwifery mentor, ideally on women with epidurals. Instead, she decided to examine herself regularly during the last few weeks of her third pregnancy, and soon worked out how to differentiate the various parts of her vagina and cervix. We would discuss her experiences over the phone every few days, and at first ~ not least because we read (and believed) the textbooks like good girls ~ we assumed that the discrepancies that she was feeling in cervical length and dilation were a result of her inexperience. The research studies called it intra-observer error and so, for a while, did we.

I can't remember whether it was a sudden or a gradual shift in our thinking, but we came to realise that the intra-observer error theory wasn't the only possibility. Even after she reached the point where she felt that she really knew what she was feeling, she would notice that, while her cervix was generally becoming shorter, thinner and more dilated, there were days when it felt somewhat longer and less dilated than it had the day before.

Saskia's experiences and cervical behaviours aren't unique, and the notion that the cervix opens in a uniform manner has been challenged in a number of written papers which could also be seen as stepping stones. Bergelin and Valentin[2] published a longitudinal study identifying several different patterns of change in cervical length and other attributes during women's pregnancies and the concept of cervical regression (pasmo) has been described by a number of midwives and researchers, who have been able to show that it is very normal for a woman's cervix to open *and* close during labour and birth.[3-5]

There is often a deep congruence between the new theories and the old stories in this area. Midwives have long understood, for example, that a woman's cervix will often regress upon transfer from home to hospital, becoming less dilated on arrival than when she left home. There is not always so much congruence between this knowledge and the behaviours of those who have not yet encountered or learned to trust it, however. It is still not unusual to hear of situations where, when a woman's cervix is found to be less dilated upon arrival at the hospital than the midwife's last record showed it to be, it is the midwife's ability to perform a vaginal examination that is questioned. Assessment of dilation is, of course, immensely subjective and clinicians of all types are prone to getting to wrong.[6] Yet the stories that we so often hear about the things that are said to midwives when this kind of situation occurs would tend to support the idea that many practitioners still believe the cervix to open in a uniform and unidirectional manner.

Rethinking Progress

The fact that the model of labour progress which has developed within medicalised settings[7-9] remains a key influence on practice further underlines the need to move towards a better understanding of normal labour. As Thorpe and Anderson discuss,

> *"Much of the research undertaken to assess 'normal' progress in labour has been undertaken in medicalised settings and has focused mainly on the rate of cervical dilatation while ignoring other physiological changes and influences"*[10].

One of the reasons that I like to use the stepping stones metaphor when discussing these kinds of knowledge is that I feel it encompasses some of the key issues that are raised when we consider the kinds of knowledge that ~ in contrast to medical knowledge ~ are gathered and used by midwives. As with stories and insights, one stepping stone on its own is rarely enough; usually, several are needed in order to form a path. We can never know, when we encounter one piece of knowledge or story on its own, whether we have found a key stone or whether we have just met the one woman whose experience differs from the vast majority. Sometimes a story or research study will contain a useful gem which needs to be further built upon. Such stones remain important, but we may realise, in time, that they do not form a part of the main pathway. Or, it may feel as if these stones are partially submerged, thus presenting the danger of making one's feet wet! In time, some of these stones might attract other similar stones around them which turn out to provide a really firm footing, while others may become damaged or so well trodden that they become chipped away and maybe less useful than others over time.

A good example of the way in which even some of the key stepping stones to wisdom need to be used in combination with other forms of knowledge can be seen in the work carried out by Leah Albers[11,12], who challenged existing theory about the rate of dilation in normal labour in healthy women. Friedman[7] originally proposed that the progress of labour could be portrayed by a sigmoid (S-shaped) curve on a graph, and this curve, which divides labour into different phases, influenced Albers' work, which focused on the active phase of labour. Her results showed that a cervical dilation rate of 0.3 - 0.5cm an hour is normal and called for increased patience in our approach to assessing progress in labour.

These findings were welcomed by midwives around the world, not least because we now had quantitative, scientific evidence that supported revision of the overall rate of dilation in labouring women. Yet the nature of this kind of research means that it can often only look at one dimension; this study challenges the overall rate of dilation but does not necessarily increase our understanding about the variations that may occur in the rate of dilation, either in different women or at different points of the active phase. This is hardly the fault of the research or researcher; the area is so complex that no single piece of work can become a path in itself. Furthermore, the very nature of the kind of research that has become privileged within Western medical approaches carries difficulties and limitations. Such findings can, however, become a key stepping stone.

Stories as Stepping Stones

A further important set of stepping stones which may lead towards a fuller understanding of how women's bodies labour and birth is provided by the work of women such as Mercedes Perez-Botella and Soo Downe[13], and Lydi Owen[14], who reflected upon ~ and ultimately challenged ~ the notion that a woman should not push until her cervix is fully dilated. These

midwives also pointed to the value of stories in increasing our knowledge in this area, and used reflective questioning to challenge long-held assumptions that, as Owen notes, took hold in an era when women were drugged and babies were pulled from their bodies. Under such circumstances, it may well have been sensible to instruct attendants to wait for full dilatation before acting. As many midwives understand, the "rule" that has grown from this is often at odds with women's instinctive responses, which many midwives see as a valuable, albeit perhaps not infallible, source of wisdom. Indeed, "why would we feel the need to begin bearing down at 5–6 cm (or sooner) if it would shatter the gateway to the baby's outer world? [15]"

Another step in thinking was offered by Robbie-Davis Floyd, who retold a conversation that took place between two midwifery educators about an issue that had arisen amongst their students:

> *"...who seemed to be telling women to push too soon, resulting in swollen cervix and difficult pushing. Trying to understand the source of the problem, Sandi did a repeat [vaginal] check after one of the students had checked a woman and pronounced her ready to push. Sandi knew the mother was not ready at all. She gently conveyed this to the student, who, looking very confused, went off into a corner, surreptitiously got out a tape measure and measured her fingers as she held them apart. Sandi suddenly realized that the problem was not the student but the teaching she had received from Sandi herself. 'It's not about ten centimetres!' Sandi exclaimed. 'When I checked the mother her cervix was ten centimetres dilated, but I could still feel the cervical lip. It's not about ten centimetres!' [16]"*

A simple focus on quantification of the cervix is clearly, for so many reasons, neither useful nor appropriate. Such stories might become stepping stones in making important points yet, again, each of them may also raise other questions. One question that this story raises for me is; should we be 'telling' women when they 'can' or 'should' push any more than we should be telling them when they shouldn't?

The Journey Continues...

On the whole, my answer to the above question at this stage in my journey would be "no", yet I also acknowledge the importance of 'never saying never'. In addition, as I have noted elsewhere in this issue.[17] I find I use vaginal examination less and less as a tool for assessing progress in labour as my midwifery experience expands. There are lots of reasons for this, but one of the key ones is that I have come to understand from my own experience and the stepping stones that have emerged from being with women that I can learn more about the progress of a woman's labour from other signs, including the way she moves, vocalises and behaves. Alongside this, I have increasingly come to understand how the current state of the cervix is only one element of what we describe as progress in labour, and the quantification of this is (in my experience) only helpful on occasion rather than routinely.

While some people find such questions and the relative uncertainty that exists around birth-related knowledge to be confusing, I believe that such a state is vital for the continued growth of that knowledge. In the same way that good research studies often raise more questions than they answer, the questions raised when we step on one stone may form the basis for the next. In this regard, taking the position of 'the alien' can sometimes be helpful in enabling us to question what we know and to look at things from a different perspective.

I noted at the beginning of this article that the stepping stones described in here are only a small and random collection of our knowledge about

the cervix, which is, in turn, only one aspect of midwifery. As I near the end, I find myself recalling other women's stories and further thoughts of my own as well as realising that I have not even touched upon some of the key work in this area ~ for instance, Ina May Gaskin's concept of sphincter law[18,19] and Claire Winter's research which described British independent midwives' view of progress in labour as "orderly chaos"[20]. I should perhaps be concerned that I have not mapped the path in its totality, but I am not. The final key element of the stepping stones metaphor is that, while some stones are undoubtedly shared amongst groups of midwives, the path to knowledge is ever-changing and unique to each of us. I suspect that this is inevitable because, no matter how many lines and curves are drawn in textbooks, the real learning will always come from our own and birthing women's stories.

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Sara Wickham is an independent midwifery lecturer and consultant and speaks widely on birth and midwifery-related topics. Sara has recently completed her PhD which explored holistic midwives' knowledge in relation to post-term pregnancy.