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Experiences with Introduction of the Gentle Delivery

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Abstract: This paper discusses the experience with introduction of delivery according to Leboyer and delivery in presence of the father in the Czech Republic. The project was launched in 1981, when the deliveries according to Leboyer with the following rooming-in care started to be carried out. There is total silence in the delivery room and it is shaded. The newborn's umbilical cord is cut off only after the baby has started spontaneous pulmonary ventilation and then the newborn is placed for a while in a little bath tub with warm water. There has been an overall excellent experience with this course of delivery, the mothers accept the rooming-in without problems. After several years of practice with this kind of delivery, the couples were enabled to give birth together. About 10 per cent of the couples decided to chose this possibility. Our experience shows that this kind of care does not increase the risk of either the mother or the baby and is almost without exception regarded as much more pleasant. The mothers feel that they are not being manipulated and also feel much safer. The limits of this method lie in its increased emotional requirements for the staff and thus it is necessary to put the working team together according to more demanding criteria.

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As a young psychologist, who had just graduated, I was full of energy and enthusiasm – maybe due to the lack of information about the complexity of this world. That is why I had enough courage to start (together with my colleagues – one pediatrician and one obstetrician) a project, which was quite unique in Czechoslovakia at that time. We worked in a small regional hospital in Ostrov, a town in west Bohemia, where about 800 deliveries were carried out every year.

Fortunately, by chance, we got in contact with the work of Frederick Leboyer and found out about his attempts to get back to the method of the so called gentle delivery. At that time Michel Odent from the Pithiviers lectured in Czechoslovakia. And what we have tried seemed almost impossible: to start with a new type of delivery. It was not new as far as the technique was concerned, but it was new with

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respect to the newborn competence and the dyadic mother-infant relationship from the very first moments after the birth.

In the spring of 1982 it was very difficult in Czechoslovakia at that time to introduce this new attitude without any experimental data being available, without any support of the established authorities and with only a silent consent from the chief consultant of the obstetric department. In that respect, a small town had some advantages in comparison to the bigger ones, not only because the hospital staff knew each other much better. It was also easier to put together an enthusiastic team.

Also members of the staff and the patients knew each other personally. On the other hand, thanks to the relatively "smaller workload" at a small department, closer and more reliable relationships developed between the staff. The fact that our work is evaluated by people, whom we meet quite frequently outside the hospital also helped us to be able to develop the project. We followed the methodology developed by Leboyer.

The actual introduction of the new method was preceeded by a year of careful preparations. All the staff was informed in great detail about the new conception of the delivery and care of the newborn. We had to win interest in the new style of work by every person individually. Sometimes it was most difficult to change the very basis of their thinking and the accustomed approach toward the mother and child. The capacity of some of the medical personnel, especially the older ones, to change their previous roles as unrestricted rulers into the roles of qualified helpers full of compassion, proved to be limited. Despite the consistent training and instruction we were not fully satisfied in day to day practice. For that reason some of the personnel left for some other work position which was not so emotionally demanding for them. Some of them adapted themselves at least to the external form of the method although their full inner acceptance of it was lacking. However, the majority of our employees fully accepted the new method and became our active collaborators.

We followed the actual procedures developed by Leboyer as closely as possible. Peaceful atmosphere in the delivery room, with full acceptance of the woman in labour and compassion toward the newborn is fundamental. From these basic prerequisits result the specific steps of Leboyer's methodology. In the delivery room there is total silence, the necessary conversation is carried out in whisper or in a muffled voice. Especially after the child has been born the stress is put on silence. The delivery room is shaded, the lights are subdued. Our mothers give birth in the conventional position on their backs. Immediately after the birth the baby is placed on the mother's belly, in the face to face position, without cutting the umbilical cord. The cord is cut only after the baby has started spontaneous pulmonary ventilation. We encourage the mother to make tactile contact with the baby's back. Most mothers spontaneously start some verbal contact with their baby. After the initial cry many babies calm down completely. When the umbilical cord has been cut, the baby is placed in a little bath tub with its face above the water, the temperature of which is 37 °C. For most of them the bath is very relaxing. If the baby does not stop crying by then, it certainly does after the bath. The baby gets really relaxed in the little bath tub, opens its eyes, watches its surroundings, some of them even start to smile for the first time.

We can quite clearly perceive the relaxed behavior of the baby and the calm expression on its face as opposed to the behavioral signs of anxiety, which are common in babies born in the conventional way. It is unpleasant for the baby to be taken out of the water at once, so we divided this procedure into two or three steps. After the baby's navel has been treated and the newborn has been dried with a towel and wrapped in it, it is placed back to its mother's belly. By now the babies are already more lively and some of them seek for their mother's nipple on their own and start to suck the milk. After a certain period of time this is followed by conventional regime with the full rooming-in care.

Our worries that certain problems during the introduction of the labour according to Leboyer might occur, proved to be unnecessary. There were no additional complications, quite to the contrary: the satisfaction of both the mothers and the medical stuff has much improved. Initially we thought that we were going to have the mothers choose whether they wanted to give birth according to Leboyer or whether they wished to have a conventional delivery. But in the end we decided to introduce this kind of care, which we consider to be optimal, as obligatory. Only exceptionally, in some specifically indicated cases we introduced half rooming-in regime instead of the full rooming-in.

Even though we initially haven't counted on it, after several years of this care, we came to the conclusion that the presence of the father during delivery is useful and meaningful. We tried to have one doctor and a nurse taking care of the woman in labour so that she develops a closer relationship with them. It is a well-known fact that the presence of the support person is very important for the mother and the closest support person is, of course, the partner. After five years of experience we succeeded in building a special small delivery room where the father was invited and could be present. Just as our mothers were informed by their doctor about the type of care we provide in our maternity hospital, they were also informed about the fact that now they can give birth in the presence of their partner. It became clear that about 10 per cent of couples were interested in giving birth together. The role of the father during delivery is not a passive one, not only is he a person who is very important for the woman because of the intimacy of their relationship, but he also helps her by special massage to be able to bear the pain more easily. He also becomes a very important mediator between the woman in labour and the medical personnel.

The presence of the father has a very positive effect. The mother is calmer and more able to cooperate with the personnel. Mutual communication becomes easier. We were expecting problems – both medical and social, but fortunately we did not have to face great difficulties. For interested couples, this type of delivery has become a standard one. The feedback was almost entirely positive.

We try to train and instruct all the couples interested in giving birth together. We invite them for instruction meetings, where they find out, not only about how the delivery looks and what their particular roles should be, but also how to deal with delivery distress together. Partners learn how to press the appropriate acupressure points, which help to lower the pain of the mother. However, in practice it proved to be impossible for all the couples to attend the special training. This is especially true about couples who decide to undergo the delivery together as late as when they actually enter the hospital. But even with these couples there are no major

problems. It has become clear that positive motivation is the basic premise for the satisfactory course of the delivery.

Gentle delivery, full rooming-in and the father's presence in the delivery room are not just a method, but also an expression of compassion for the mother and the newborn. I only hope that we will be able to give that, which we have received ourselves.

In any case, the number of institutions providing this type of care in the Czech Republic is increasing.

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