A midwife friend asked me recently whether, during a baby’s birth, I routinely felt for the cord around the baby’s neck as it emerges. I replied that I didn’t, not least because I tend to be quite ‘hands-off’ about catching babies. I explained that I would be very reluctant to cut the cord at this point anyway, with the dual impact of severing the baby’s oxygen supply and interfering with placental circulation during the third stage. While this was my friend’s practice too, she had been questioned by another midwife, who felt that routinely feeling for the cord was an important aspect of her practice when attending a woman in labour.

As a student, I had learned from midwives that the cord being around the baby’s neck was only very rarely a problem; the baby will usually slide through a loop (or two) or cord, and cords are rarely so short as to cause problems. I had also heard the occasional horror story of a birth where a midwife had cut a cord that was deemed to be so tight around the baby’s neck that it was hindering the baby’s birth, only to realise that she had just made the fatal cut in the oxygen supply of a baby who had shoulder dystocia. It seems imperative to me to be completely sure that the ‘stuckness’ is caused by the cord and not by the shoulders being impacted instead – the babies who appear stuck and may get their cords cut accordingly are the very last babies who need their lifeline severed.

On the other hand, cutting the cord before the baby’s body is born might also be a life-saving practice. Just because something is not a routine part of one’s practice doesn’t mean that it might not be an occasional one. Another friend of mine told me about a birth she had attended where she simply could not have got the baby out without cutting the cord first. If a baby seems to be taking her time to come out, I am not averse to asking the woman if I can feel around and try and establish what is happening.

Overall, my feeling is that routine and unnecessary fiddling with the cord may interfere with placental separation and the third stage, as well as being potentially unpleasant and disempowering for the woman and irritating for the baby. I know other midwives who are more ‘hands-on’ in their practice, yet are still totally “with” the woman in enabling the kind of birth she hopes for. We are also becoming aware of the existence of other options at this time, such as the “somersault manoeuvre” (see below), where the baby can be born without the cord being cut despite the cord being tightly around the neck.

Aside from the possible impact on physiology, it is the stories of women such as Midwife Bev Lynn, who spoke out about her own experience in labour which should make us to pause to think about feeling for the cord:

“It was dreadful. It hurt so much.
When the midwife felt for the cord, it felt like somebody was sticking knitting needles into my clitoris.” (Bev Lynn 2002, personal correspondence).

The midwife who had initially questioned my friend was interested in this debate and had asked her if she had any ‘evidence’ to support her practice of not feeling for the cord. This was the question my friend then asked me. I carried out a quick search and found very little on this in the research literature. Perhaps unsurprisingly, nobody has carried out a randomised controlled trial to see if it is better to ‘feel’ or ‘not feel’. In fact, any such study would be unwieldy; needing arms to deal with the other follow-on aspects of this practice; looping the cord over the baby’s head, allowing the baby to be born through the cord, cutting the cord. Imagine a trial where midwives are asked to record how many loops of cord were around the neck, how long the cord was and what they did; far too many confounding variables to tell us anything sensible. I couldn’t find anything relating to this practice mentioned in the CESDI report either; it is one of those hidden practices that rarely get debated on a wider level.

This is another reason that we must look at evidence other than that gathered from quantitative research. The midwife who makes the assumption of normality learns when to occasionally feel for the cord through experience; she gathers knowledge by listening
to the stories of others and taking into account her understanding of the physiology of birth. She might find out about the history of this practice – knowledge that can sometimes put the practice into a clearer context. Sometimes she makes a decision in the heat of the moment of birth through intuition alone, leaving her to reflect upon the situation later and put this new experience into the context of her knowledge.

Yet, after thinking about all of this, I am left to ponder the question that bothers me the most. Whether or not we do things like this as a regular part of our personal practice, why do we feel we need research evidence to support the argument for not intervening? In a model of midwifery that assumes normality, I would assume that midwives would need to see evidence that something is useful before it into their practice, not the other way around. Have we become that uncomfortable with the physiology and normality of birth that we would rather intervene than not? Are we so fearful of litigation that we feel we need to “do” rather than “be with”? And are these practices really so ingrained in us that we feel compelled to continue them on a routine basis unless – or until - they can be proven unhelpful?

For the text of a midwifery discussion about the “somersault manoeuvre”, see www.gentlebirth.org/archives/nuchlcrd.html