2004 White Paper

This White Paper is an academic exploration of 21st century maternity care with citations and links to the scientific literature. It was prepared by the **C**onsortium for the **E**vidence-base practice of **O**bstetrics

C.E.O.

is dedicated to bringing science-based maternity care to all childbearing women

A-C.E.O ~ The American College of Evidence-based Obstetrics ~

For physicians who wish to re-establish the scientific foundation of their profession and reclaim their expertise in the use of physiological management for normal birth

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Stedman's Medical Dictionary definition of **"physiological" – "…in accord with or characteristic of the normal functioning of a living organism"** (1995)

"Obstetrics has been *rated as the least scientifically-based specialty in medicine*"

Dr Ian Chalmers 1987.

"The hallmark of obstetrical quality is the prevention of the rare disaster *rather than the optimal conduct of the many normal cases*" Dr. Brody 1981

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Reading time approximately **35 minutes**

21st Century Maternity Care ~ Meeting the needs of our childbearing population while remaining competitive in a global economy

Introduction

Preserving the health of already healthy mothers and babies is the **primary role of maternity care.** Traditionally this has been accomplished by protecting mothers and babies from the rare mistakes of Mother Nature *and* the frequent excesses of 20th century medical intervention. The classic method for serving healthy childbearing women is known as "physiological management". Its classic principles are **"…in accord with, or characteristic of, the normal functioning of a living organism".**

In this science-based system, physicians and midwives all over the world are **taught to utilize physiological management** for normal pregnancy, labor and birth. These protective methods include a commitment not to disturb the natural process. A non-interventive approach includes continuity of care, patience with nature, one-on-one social and emotional support, non-drug methods of pain relief and the right use of gravity. Obstetrical intervention is reserved for complications or if the mother requests medical assistance.

These physiological principles provide the safest and most cost-effective form of maternity care. According to the World Health Organization, it is the preferred standard for healthy women. W.H.O. refers to this as the "**social**" model of childbirth; most countries depends on these low-tech / high-touch methods to provide cost-effective care. In the US, this is often called "Family-centered" or "Mother/baby/father-friendly" maternity care. Approximately 70% of pregnant women in the United States are **healthy and have normal pregnancies**. That is approximately three millions normal births annually.

Mastery in normal childbirth services means bringing about a good outcome *without introducing any unnecessary harm*. Our present system of obstetrics for normal childbirth does not do this very well. In fact, our maternal-infant mortality record has been remarkably dismal throughout the 20th century. This is because obstetrical interventions, originally developed for complications, are inappropriately used on healthy women. This frequently introduced unnatural risks and unnecessary complications. These avoidable problems disturb the normal biology of labor and birth by routinely applying of medical and surgical interventions to nearly 100% of the childbearing population.

In spite of spending **more money that any other country in the world**, the United States is 30th in maternal mortality and 22nd (third from bottom) in perinatal mortality. The five countries with the best mother-baby outcomes only spend a fraction of the money we do. These countries all have national maternity care systems that depend on physiological management for healthy populations.

To determine the quality of care received by mothers in the US, the Maternity Center Association of NYC recent surveyed healthy women with normal term pregnancies who gave birth in the previous 24 months. The survey revealed than an average of ***seven or***

more serious medical or surgical procedures performed on each laboring woman (*'Listening To Mothers'* survey by the Maternity Center Association of NYC, October 2003). That means about three million healthy childbearing women are exposed annually to unnecessary obstetrical interventions. Healthy childbearing women have been unwitting subjects in an unregulated medical experiment without truly informed consent for more than a century. This is a very long history of non-consensual medical treatment forced on mentally competent, adult women with normal pregnancies.

A healthcare system that over treats three-quarters of its patients is both expensive and dangerous. It exposes mothers and babies to unnecessary physical and mental suffering and increased rates of preventable death and disability. Recently the obstetrical profession has upped the ante by promoting the strange idea that an 'elective', or medically **unnecessary,** 'maternal choice' cesarean is *safer than normal childbirth*. Many in the obstetrical profession predict that cesarean delivery will completely replace normal birth within the next 10 or 15 years to become the official "standard of care".

However, medical journals make it clear that routine obstetrical intervention for healthy women and normal birth conducted as a surgical procedure is **always more dangerous** than the use of physiological principles with appropriate social and psychological support. Scientifically speaking, this is *not* a controversial finding. Reliable scientific evidence is neither lacking nor incomplete, nor is this data the subject of methodological disputes.

This irrational and unscientific system misdirects scarce economic and human resources that could more properly be used to treat the ill, the injured and the elderly. All forms of healthcare combined accounts for 17% of the Gross National Product. Obstetrical care accounts for 1/5th of the entire health care budget (equal to 3.4% of our GNP). Seventy percent of those maternity care expenses (2.4% of GNP) are inflated by applying unneeded medicalization to healthy women, which generates additional (and expensive!) complications, both short and long-term.

The bill for this failed medical experiment is being passed on to the public and to employers through the Medicaid tax burden and the increased cost of health insurance. In order to remain competitive in the global economy, many industries are outsourcing manufactured goods and replacing service jobs with off-shore workers. Economists have

identified our inflated health care costs as a major factor in these cost-cutting measures that depress our economy and deprive American of much needed employment.

To meet the practical needs of childbearing families while remaining competitive in the global free market, the US must utilize this same efficacious form of maternity care as the countries with the best, most cost-effective outcomes. An improved and cost-effective system would permit limited health care dollars to be properly used to meet the medical needs of the truly ill. Compassionate, effective and affordable maternity care is to the mutual benefit of mothers, babies, fathers, families and society in general.

The only way our healthcare system can meet the needs of our healthy childbearing population, while remaining competitive in the global economy, is to implement the social model of pregnancy and childbirth care case as the basis for our national maternity care policy.

The challenge for the 21st century is to bring about a **fundamental change in maternity care** in the United States. Normal childbirth services for healthy women must be scientifically-based, compassionate and fiscally sound. This rehabilitated policy would integrate the classic principles of physiological management with the best advances in obstetrical medicine to **create a single, evidence-based standard for all healthy women used by all maternity care providers**.

Direct consumer access to research affirming the data and assertions presented in the CEO White Paper are available in the Maternity Center Association's publication "**Listening to Mothers**" and **"What Every Pregnant Woman Needs to Know About Cesareans".** We strongly recommend down-loading PDF copies of these and the other excellent documents on evidence-based maternity care at **<www.maternityWise.org>.**

♥ Chapter One -- **How Did Things Go So Wrong?**

"Obstetrics has been *rated as the least scientifically-based specialty in medicine*"
Dr Ian Chalmers 1987.

"The hallmark of obstetrical quality is the prevention of the rare disaster *rather than the optimal conduct of the many normal cases*" Dr. Brody 1981

Obstetrics is an important surgical specialty originally developed in Europe during the 17th and 18th century. It was a logical response to the pathological conditions associated with pregnancy complications, obstructed childbirth and other reproductive abnormalities. When mothers or babies need to be rescued from life-threatening complications, modern obstetrical medicine does a technically superb and compassionate job. None of us would choose to live in a world without its pain-relieving and life-saving capacity.

However, it routinely fails in the arena of normal maternity care. This failure is identified in the quote by Dr. Broody as the obstetrical profession's inability to excel in the "optimal conduct of the many normal cases". Of equal or greater consequence, interventionist obstetrics also fails to meet the actual and practical needs of healthy childbearing women and their families, which includes the social and psychological process of becoming a new mother and developing competencies and confidence in parenting skills. No one in the obstetrical profession has or is purposefully making childbirth hard for women --medicalized childbirth is well intentioned -- but it misses the mark in all these essential areas. In addition, the cost-benefit ratio is backwards and badly out of step with the global economy.

In the last hundred years obstetrics for *healthy* women has devolved into an **ideology** similar in its effect to a political or religious point of view. This ideology gives rise to the illogical conclusion that *normal* childbirth requires a constant stream of technological surveillance and medical & surgical interventions. An irrational exuberance for all things medical, combined with the rejection of other points of view, is detrimental to the goal of safe and cost-effective maternity care. Obstetrics is an “expert” system that has **failed *most* in the very area it was supposed to have the *most* mastery and expertise** -- preserving the health of already healthy mothers and babies. An operative rate well over 50% confirms that the **introduction of harm has been institutionalized** and thus the obstetrical profession has fallen down in its most basic responsibility --- “**in the first place, do no harm.**”

Obstetric ideology prefers a rigid moralistic vocabulary. It gives rise to a black/white, right/wrong view of the topic that defines technology, drugs, medical interventions and surgical procedures as right and safe, while implying that all other options are wrong and dangerous. In the last fifty years, the onward march of obstetrical intervention has progressed from the “knock’em out, drag’em out” style of the 1940s, 50s and 60s to the "maternal choice" cesarean of our times. This progressive medicalization started in the early 1900s with the routine use of ‘twilight sleep’ (i.e., narcotics and

amnesic drugs), general anesthesia, episiotomy, forceps and manual removal of the placenta. Until the 1970s, the Cesarean rate remained under than 5% while instrumental delivery (forceps) and episiotomy was more than 90 percent.

In the last three decades, obstetrical medicalization has changed in many ways but it is still an aggressive and interventionist model. In the year 2000 more than **50%** of labors were routinely induced or accelerated with Pitocin. Epidural has replaced general anesthesia as the norm; the cesarean section rate for 2002 was 26.1 percent (26.8% in California). Too many normal pregnancies culminate with the same operative delivery techniques used in the 1950s -- episiotomy and forceps (or vacuum extraction) -- and healthy babies spend time in the neonatal intensive care unit as a result of breathing problems or birth injury. This mismatch of care is expensive and harmful.

The most recent evidence of this irrational exuberance for surgical intervention is a media campaign by the obstetrical profession to promote the notion that an 'elective', or medically **unnecessary,** 'maternal choice' cesarean is *safer than normal childbirth*. This public-relations campaign was topped off on October 31, 2003 by a press release by the **American College of Obstetricians and Gynecologists' (ACOG).** The news report announced a decision by their Ethics Committee, decreeing that it was now considered it "ethical" (based on ACOG's professional code of ethics) for obstetricians to perform medically unnecessary cesarean surgeries. This decision was based, in part, on ACOG's insistence that there was: "a lack of data on the risks and benefits of cesarean vs. vaginal delivery". According to published scientific sources, this statement is, on its face, false and misleading. The Maternity Center Association's excellent systemic review of the scientific literature entitled "***What Every Pregnant Woman Needs to Know About Cesarean Section***" documents this for the lay public. (PDF file available on line at <www.maternityWise.org>)

This strange conclusion trivializing cesarean section is the predictable outcome of a century-long PR campaign by organized medicine**.** Beginning in 1910, the formal strategy of the obstetrical profession was to *discredit physiological management* as old-fashioned and dangerous and replace it with the idea that normal birth was now a surgical procedure to be performed by doctors. According to this dubious theory, childbearing was inherently pathological. Physiological methods were portrayed as inadequate and *no longer to be tolerated by an enlightened medical profession and a discerning public*. This propaganda exploited the lay public's lack of scientific knowledge about normal birth, combined with an unquestioned faith in medical "science".

The belief that normal childbirth was inherently dangerous gave rise to **an unregulated medical experiment -- interventionist obstetrics as the norm for healthy women with normal pregnancies**. No matter how logical and well meaning this theory seemed originally, the *unintended consequences* of it were negative and far-reaching. In the United States, organized medicine built an obstetrical care system in the early decades of the 20th century based on the idea that every pregnancy was a "nine-month disease" that required a surgical solution. The obstetrical profession has never reassessed this untested hypothesis, which continues to underpin their interventionist philosophy today.

However, approximately 70% of all pregnancies are normal and occur to women who are healthy. Healthy women do not benefit from a medical regime that disturbs the spontaneous biological process. The principles of physiological management -- i.e., care *"in accord with, or characteristic of, the normal functioning of a living organism"*-- **provide the safest and most cost-effective form of care for a healthy population**. This is regardless of the category of caregiver (doctor or midwife) , the educational status of the practitioner (OB, FP, CNM or LM.) or the location chosen by the parents (hospital, home or birth center).

Historical knowledge-base destroyed and traditional forms of care replaced

The obstetrical profession's age-old denunciation of midwives is a result of their peculiar world view that defines normal childbirth as abnormal. Organized medicine's Hundred Years' War on midwives was the occupational equivalent of an ethnic cleansing. The stated objective was to erase from the scientific literature the institutional memory of the physiological principles and the traditional skills used by midwives to facilitate normal childbirth. This resulted in an obstetrical Dark Ages, aptly described as *flat earth obstetrics*, that has spanned the entire 20th century.

> **Flat earth obstetrics** is the belief that medical and surgical interventions are necessary in every normal childbirth, despite evidence that such a policy is harmful. The term is derived from the insistence by religious and political leaders during the Dark Ages that the earth was flat despite evidence to the contrary.

Flat earth obstetrics believes that every healthy woman inevitably benefits from the care of a surgical specialist. This introduces harm by exposing healthy mothers and their unborn babies to

unnecessary, potentially risky interventions while depriving them of the protective and preventive strategies of physiological management. Interventionist obstetrics is failure by design, as such a design applied to a healthy population can only fail. It is a one-two punch that consists of *absence of the right stuff* along with the unwarranted and unhelpful *use of the wrong stuff*.

The greatest realistic danger today for healthy women who are well-fed, well-housed, well-educated, and well-cared for during pregnancy is obstetrical over-treatment and its many complications. For a healthy woman, her most pressing needs during a normal pregnancy are primarily social and psychological. Relative to labor and birth, her greatest needs are met by the philosophy and principles of physiological management that includes continuity of care and the full time presence of a skilled and supportive practitioner during active labor. Physiological management depends on the right use of gravity to naturally promote biological progress and continuous one-on-one labor support to help the mother cope with the stress and pain of labor without having to resort to the use of potentially dangerous drugs. This strategy avoids the multiple side effects and complications that accompany artificial hormones, narcotics, anesthesia, episiotomy, instrumental and operative delivery.

The negative influence of flat earth obstetrics is amply documented in historical sources, scientific studies, professional journal articles and insider reports. Merely reading the headlines from **Ob.Gyn.News**, the largest trade paper for American obstetricians, shows how the insider story, written *by and for* obstetricians, is far different from the one promoted in the public press. While the obstetrical profession thinks of its practice as logical, science-based and safe, the actual facts reveal this form of **routine interference in *normal* pregnancy and birth** to be illogical, unscientific and harmful.

The established scientific method as used through out the 20th century requires that the burden of proof fall on those who develop a new theory or propose to eliminate the use of established methods. When promoting a 'better way', science requires the 'scientist' to first validate its merits scientifically before claiming its superiority or usurp the original method. The scientific process has never been applied by obstetricians to obstetrical intervention for healthy populations. As judged by the scientific method, 20th century obstetrical care by surgical specialists for healthy women is a **failed medical experiment**. Reform is long over due.

♥Chapter Two -- The uncritical acceptance of an unscientific system of maternity care

For the last century, scientific analysis of interventionist obstetrics for healthy women has *never been able to demonstrate superior outcomes*. Worse yet, scientific studies and vital statistics between 1910 and 1930 show a 15% annual increase in maternal deaths for more than a decade and a 44% increase in neonatal birth injuries over the same period. The escalating rate of mortality and morbidity was the direct result of replacing the safer, physiologically-based care of midwives by obstetrical interventions which included the routine used general anesthesia, episiotomy, forceps and manual removal of the placenta.

However, the poor statistical showing of obstetrics has always been **interpreted** to mean that the prevailing **level of intervention was inadequate**. Thus the statistically-documented failure of interventionist care has actually *spurred an ever-increasing rate* of medical and surgical interventions, up to and including the "prophylactic cesarean." This is **not** a criticism of obstetrical care for women with high-risk pregnancies and serious complications, for whom interventionist care can be life-saving.

Tactics properly reserved to treat obstetrical complications and emergencies have instead become an all-purpose **strategy** for providing care to the entire population of healthy patients. An example of confusion between tactics and strategy would be attempting to use the *tactics of war* against an armed enemy as a *strategy for maintaining peace* in a civilian population. Interventionist obstetrics for healthy women with normal pregnancies adds unnatural dangers to otherwise normal biology. It advances a false and misleading claim of *value added* over that of physiologically-based care. In reality, obstetrics for healthy women is an inefficient, *value-subtracted* system. The promotion of interventionist obstetrical care for healthy women by ACOG is self-serving and potentially harmful.

Without truly informed consent, healthy childbearing women have been unwitting subjects in this medical experiment for more than a hundred years. This equates to non-consensual medical treatment. The bill for this failed medical experiment is paid by the public and by employers through the increased cost of health insurance and the Medicaid tax burden. Our inflated health care costs are identified by economists as a major reason for employers to choose cost-cutting measures, such as outsource manufactured goods and replace service jobs with off-shore workers, so as to remain competitive in the global economy.

Contemporary obstetrical practices for healthy women were founded on a 19th century **reductionist view of childbirth.** In a reductionist view, the rich tapestry of childbearing, with its emotional nuances and long-term social consequences, is reduced to mortality statistics. Since childbirth is a fundamentally successful biological system, healthy mothers and babies generally survive and leave the hospital alive -- the medical definition of a 'success'. But in the reductionist view, physical or psychological damage to mother or baby (such as operative or instrumental delivery) and unmet social and psychological needs are not factored into the equation.

The Baby Business -- a close cousin of the hormone-intensive Agra-Business

In addition, the profession of **obstetrics is inextricably mixed up with childbirth services as the huge and lucrative 'baby business'**. A revealing example of this can be seen in the following excerpts from *Ob.Gyn.News* on the off-label use of misoprostol to induce labor. Misoprostol (trade name 'Cytotec') is a drug marketed to treat stomach ulcers. When used in obstetrics, it is associated with an increased rate of uterine rupture. None the less, Dr. Maslow, director of maternal and fetal medicine at the Geisinger Health System in Danville, Pa. is rhapsodic in his description of the financial advantage to the hospital industry when normal birth is managed as a form of 'Agra-business'. Just as hormones are used to boast egg & dairy production and to speed up the weight gain of cattle, so too the obstetrical system uses artificial hormones to manipulate birth-related body functions. This permits them to put biological processes on the clock, so they are more convenient and profitable for the institution:

> Oral misoprostol is far and away the most cost effective labor induction methods, Dr Arthur S. Maslow asserted at meeting .... **The best part about it is that you can block-schedule your nurses** so that you have enough on hand. With a 90% successful induction rate within 8-10 hour, if we start our inductions at 7 a.m., we know that we're going to have X number of patients being admitted by 4 p.m. **That's helped our hospital tremendously…**

Referring to the drug misoprostol, Dr Maslow remarked:

> Its a great agent. It works very, very efficiently. Its very safe ..... **And it's ungodly inexpensive: 27 cents per tablet**. **At the most we use two or three tablets.**

Discussing of how Cytotec / misoprostol induction is best managed, Dr Maslow had this advise: ...

> ....the patients arrive at the antepartum diagnostic center first thing in the morning .... given a single oral 50-ug tablet..... monitored for the next hour .... **Then we make them walk for 2 hours**. They can stay in the hospital, go to the mall, I don't care. **Just don't rest them during an induction. You're killing your hospital financially if you do that, just killing them. Its not fair to the hospital .....**

Comparison of Maternal Mortality Normal vaginal birth vs. Cesarean section

The obstetrical profession continues to promote the 'maternal choice', or medically *unnecessary* cesarean as the ideal form of childbirth. This misleading claim seems to have far more to do with being "fair to the hospital" than safe for the mother. Scheduled surgery permits the practice of 'daylight obstetrics' while maximizing the physician's time and economic compensation and keeping hospital beds full. Many doctors predict that within the next 10-15 years, scheduled cesarean delivery will replace spontaneous vaginal birth as the obstetrical standard. Unfortunately, this major abdominal surgery is also associated with a *2 to 4-fold increase* in **preventable maternal deaths**.

Maternal mortality associated with *vaginal birth is rare* -- only one out of **16,666**. To put this number in perspective, the annual ratio of auto accident fatalities for women of childbearing age are one out of **5,000**, so it is more than 3 times **safer** to give birth normally than to travel in a car. However, when cesarean sections are performed, the maternal death rate jumps to 1 out of **3,225**. To put that number in perspective, consider that terrorist-related deaths for Israeli citizens is only one per **10,000**, making scheduled cesarean surgery **three times more** dangerous to childbearing women than living in the midst of the Israeli-Palestine conflict and six times more dangerous than normal vaginal birth.

In addition, there are serious, sometimes fatal problems for babies delivered by cesarean, such as surgery-related prematurity, surgical lacerations, respiratory distress. These complications require neonatal intensive care nursing and expose an otherwise healthy baby to NICU acquired, antibiotic resistant infections such as necrotizing enterocolitis.

Necrotizing enterocolitis (NEC) is the most common gastrointestinal medical and/or surgical emergency occurring in neonates. Outbreaks of NEC seem to follow an epidemic pattern within nurseries, suggesting an infectious (i.e., iatrogenic) origin. While its more common in premature infants, it also occurs in term babies. Mortality for NEC for term infants is reported to be 4.7%. Of

those patients who survive, 50% develop a long-term complication. Depending on the location and extent of the bowel removed, long-term morbidities includes the need for colostomy, repeated surgical procedures, prolonged IV feeding, poor nutrition, malabsorption syndromes, failure to thrive/short gut syndrome and multiple hospitalizations.[Necrotizing enterocolitis by Shelley C Springer, MD, MBA, MSc et al, November 25, 2002]

As can be seen from this list of complications and mortality associated with surgical interventions, it is a profoundly dangerous misunderstanding to assume that the biology of normal birth is defective. This regrettable attitude by the obstetrical profession culminates in the politics of the '**pre-emptive strike**' and the **hair trigger**. For healthy women and babies, the greatest risks are *not* the rare unpreventable complication of normal biology but the frequent preventable complications stemming from the routine use of electronic monitors, IVs, immobilizing laboring women in bed, routine use of uterine stimulants to accelerate labor, narcotics, anesthesia, surgical procedures and surgical instruments and admission of the newborn to special care nurseries. Obstetrical intervention makes normal childbirth into a war zone for healthy women and their babies.

The cognitive dissidence between the woman's view of her maternity care and the medical-industrial complex's view is huge. The obstetrical profession sees childbirth from the same narrow perspective that infertility specialists see conception. Since making love and being artificially inseminated both result in pregnancy, they make no distinction between the two. This depressing situation is the predictable consequence of purposefully preventing the corrective and humanizing influence of physiological management from being applied to the field of normal maternity care.

Midwifery management, which depends on physiological principles, and interventionist obstetrical care *both produce equal results* as measured by babies born alive and without neurological damage. What is remarkably different and missing from obstetrical management is the opportunity to address the full spectrum of maternal, infant and societal needs. **Pregnancy "produces a mother as well as a baby".** Good maternity care should address the all these needs-- physical, psychological, social and developmental, especially as it relates to preparing women to mother their new baby. In the physiological model, the interests of the mother are *not seen as in conflict with those of the baby*. Instead the mother-baby are seen as a unit or couple with complimentary needs. With rare exception, what is good for mothers is directly or indirectly good for their babies.

What works and why bother ...

At present, it is virtually impossible for healthy families to get the safe care they deserve from hospital-based obstetrics. As contrasted with the medical model, **physiological management of normal labor is protective** of both mothers and babies, reducing the surgical rate from over 50% to **under 5%,** with equally good perinatal outcomes. These protective methods, as provided by midwives and a small number of physicians**,** include **a commitment not to disturb the natural process**.

Its principles constitute the "social" model of childbearing identified by the World health Organization as the preeminent system to provide normal maternity care. In the United States the social model is also known as "family-centered" or "mother-baby-father friendly" maternity care. In this system, professional caregivers recognize that the integrity of the mother-child relationship begins in pregnancy. The mother is not viewed as a "patient" in the sense of being infirm or incompetent but rather as **a competent and self-directed individual**. She is acknowledged as the "primarily" caregiver of her baby, since it is the mother who voluntarily decides whether *or not* to seek maternity care during pregnancy. It is normally the mother who first notices an obstetrical problem, who voluntarily seeks out medical assistance and ultimately, **must give consent** for invasive medical and surgical treatment. It is appropriate for her good will towards her baby to be assumed unless there is clear and obvious evidence to the contrary.

The principles of social or 'mother-friendly' model depend on:

- **a respect for and trust in the normal biology of pregnancy and childbirth**
- **an expectation of normalcy in the progress of labor and birth**
- **recognition of the mother's right to choose and control the environment for labor**
- **acknowledging the mothers' right to direct her own activities, positions & postures during labor**

Its practices include:

- **continuity of care**
- **patience with nature**
- **full-time presence of the caregiver during active labor**
- **continuous one-on-one social and emotional support**
- **appropriate physical and psychological privacy for the laboring woman**
- **non-drug methods of pain relief such as walking, hot showers and deep water tubs**
- **no arbitrary time limits as long as reasonable progress, mom & babe OK**

- **vertical postures, pelvic mobility and the right use of gravity**
- **maternal choice of birth position unless medical factors require otherwise**
- **physiological clamping of umbilical cord -- after circulation has stopped (+/-3 minutes)**
- **immediate possession and control of healthy newborn by mother and father**

The relationship of the social model and contemporary medicine includes:

- **palliative treatment of minor medical deviations**
- **the capacity for emergency-response by the practitioner**
- **access to and appropriate use of the obstetrical care system, drugs and anesthesia when indicated**

The elements of success for normal labor and spontaneous birth are the same regardless of location -- home, hospital or birth center. While physiological management of labor dramatically reduces the need for pain medication or epidural anesthesia, the employment of physiologically-sound methods does **not** prohibit **hospitalized mothers** from receiving **drugs and anesthesia as desired or required**.

A socially appropriate environment is one in which the mother feels unobserved and yet secure, with emotional support as necessary. This is the purposeful mechanism of physiological management that addresses the mother's pain, her fears and privacy needs so that labor can unfold naturally, without the need for medical interventions and pain medications. It is also necessary to take into account the **positive influence of gravity on the stimulation of labor, dilatation of the cervix and decent of the baby through the bony pelvis**. Maternal mobility not only helps this process along but also diminishes the mother's perception of pain, perhaps by stimulating endorphins. To ignore the well-known relationship of gravity to spontaneous progress is to do so at the peril of mother and baby. The complex interplay of the physical and the psychological are such a **biological verity** of childbearing, that women have an **undeniable right** to have the maternity care provided to them be structured to address both the gravitational and psychological influence on the spontaneous biology of labor and birth.

Non-medical strategies that properly address these gravitational influences and the psychology of normal labor are particularly effective in averting episiotomy and operative deliveries and their subsequent complications, such as pelvic organ prolapse and incontinence. Normal management dramatically reduces the cesarean rate, which also **averts the short and long-term sequelae of cesarean surgery** for both mothers and babies. Because cesarean surgery so greatly increases

maternal morbidity and mortality, the use of physiologic principles reduces maternal morbidity and mortality for a significant number of women.

Direct complications of cesarean surgery for mother and baby include:

- **double or triple the risk of maternal death**
- **nine-fold increase in potentially fatal blood clots**
- **triple the risk for maternal infection**
- **maternal hemorrhage**
- **13-fold increase in emergency hysterectomy**
- **higher risk of lung disorders and operative lacerations for babies**
- **Cesarean babies also suffer increased rates of asthma as children and triple the rate of asthma as adults**

Post Cesarean complications associated with post-cesarean pregnancy, include:

- **secondary infertility**
- **tubal (ectopic) pregnancy**
- **increased miscarriage & stillbirth**
- **abnormal placentation (previa and accreta / percreta**
- **blood transfusions**
- **uterine rupture**
- **emergency hysterectomy**
- **maternal and neonatal death**
- **disability or neurological damage to mother and/or baby**

Healthy families seek out home-based midwifery services ***not*** *because they are indifferent to the safety of their babies*. For many families, it is their only access to the safety of physiologically-based maternity care. The best, perhaps the only, **solution to the home birth controversy** is to make maternity care in homes and hospitals **equally safe and equally satisfactory** so that families are not forced to choose home birth for want of appropriate, compassionate and cost effective care in hospitals. This leads us to the natural and compelling conclusion that our current hospital-based maternity care system must be rehabilitated.

♥ Chapter Three ~ What happens when the essential elements of success are missing

In October 2002, a national survey -- *Listening To Mothers* -- was commissioned by the Maternity Center Association of NYC. This was done in an effort to track contemporary obstetrical trends and the quality of care received by healthy childbearing women. The MCA is a non-profit organization

that has been promoting safe maternity care since 1918. They also develop educational materials for expectant parents on 'evidenced-based' practices -- that is, maternity care policies that are based on a scientific assessment of the safety and effectiveness of commonly used methods and procedures.

The determination of scientific validity is based on the published work of Drs Ian Chalmers and Murray Enkins. Their compendium, entitled *"A Guide to Effective Care in Pregnancy and Childbirth*" (GEC), is the bible for evidenced-based maternity care. *A Guide to Effective Care* maintains a review of all pregnancy and childbirth related studies published in the English language in the last 30 years. It identifies six levels of effectiveness & efficacy, ranging from the positive end of "**clearly beneficial**" (category 1) to the negative end (category 6) of "**likely to be ineffective or harmful**." Using the preponderance of available evidence, Drs Chalmers and Enkins rate the safety and efficacy of each standard maternity care practice and each regularly used medical/ surgical intervention. Based on these categories, the *Guide to Effective Care* cautions that:

> "Practices that limit a woman's autonomy, freedom of choice and access to her baby should only be used if there is clear evidence that they do more good than harm"
>
> "Practices that interfere with the natural process of pregnancy and childbirth should only be used if there is clear evidence that they do more good than harm"

The Maternity Center Association documented a "**significant gap between scientific evidence and standard obstetrical practice**." According to teaching materials by the MCA: "Healthy, low-risk women in the United States often receive maternity care that is **not** consistent with the best research". Using the rating system recommended in the *Guide to Effective Care in Pregnancy and Childbirth* , laboring women in the US are routinely exposed to a plethora of practices officially categorized as of **"unknown or unproven effectiveness," "unlikely to be effective,"** or **"known to be harmful."** According to the MCA, many people are not aware of the following major areas of concern:

- The under-use of certain practices that are safe and effective
- The widespread use of certain practices that are **ineffective or harmful**
- The widespread use of certain practices that have both benefits and risks without enough awareness and consideration of the risks
- The widespread use of certain practices that have not been adequately evaluated for safety and effectiveness

The *Listening to Mothers* survey revealed that 99% of healthy pregnant women **do not** receive science-based maternity care from their obstetrical providers. An average of **seven** medical or surgical procedures was performed on each healthy woman giving birth in the 24 months preceding the survey. They reported that there were **virtually no spontaneous, unmedicated births (i.e., without medical or surgical interference) in institutional settings**. Only 1% of this cohort of healthy women were *not subjected* to institutionalized interference and those were the 1% who gave birth at freestanding birth centers or at home. Intervention statistics from the **MCA's survey** of healthy women who delivered at term in the last 24 months are**:**

93 % exposed to **continuous electronic fetal monitoring** (associated with increased CS rates)
86 % had **IVs** while being **prohibited** from drinking or eating
74 % required to **give birth lying on their back** (increased fetal distress, instrumental and operative delivery)
71 % **confined to bed /** immobilized / not permitted to walk during labor (dysfunctional labor, + pain)
67 % had **artificial rupture of membranes** (increased prolapsed cord, infection)
63 % had l**abors induced or accelerated** with prostagladins and/or artificial oxytocin (Pitocin),
63 % had **epidural anesthesia** (increased instrumental delivery, CS)
58 % had a **gloved hand inserted into their uterus** after birth (increases bleeding & uterine infection)
52 % had **bladder catheterizations** (increases bladder / kidney infections)
35 % had **episiotomies** (increased bleeding, pain, infection, sexual dysfunction)
24 % had **cesarean** surgery (increases maternal mortality 2-4 times)
13 % delivery by **forceps or vacuum extraction** (increased fetal & maternal damage, long-term incontinence)

The total operative delivery was 37% excluding episiotomies, **72% if episiotomies are included**. It should be noted that these statistics are for healthy women at term with normal pregnancies. Intervention rates are much higher for women with premature labor, multiple pregnancies or medical complications. This accounting is consistent with data from the CDC's National Center for Health Statistics Vol. 47, No 27, *The Use of Obstetric Interventions 1989-97*, which documents a steady annual increase since 1989 in each of these major interventions. In light of these results, the Maternity Center Association recommended "**more** physiological and **less** procedure-intensive care during labor and normal birth". However, it must be noted that interventionist obstetrics makes its money from 'billable units' -- i.e., medical and surgical procedures performed.

Other Voices, Other Issues, Same Miserable Story

In an article entitled "*Elective Cesarean Section: An Acceptable Alternative to Vaginal Delivery?*", Dr Peter Bernstein, MD, MPH, Associate Professor of Clinical Obstetrics & Gynecology and Women's Health at the Albert Einstein College of Medicine, also reported on the failure of the obstetrical profession to practice evidence-based medicine. Addressing the popular notion that pelvic floor damage and incontinence were the inevitable result of normal birth (to which cesarean surgery was the proposed 'solution'), Dr Bernstein observed:

> **these adverse side effects may be more the result of how current obstetrics manages the second stage of labor**. Use of episiotomy and forceps has been demonstrated to be associated with incontinence in numerous studies. Perhaps also vaginal delivery in the dorsal lithotomy position [lying flat on the back] with encouragement from birth attendants to shorten the second stage with the Valsalva maneuver [prolonged breath-holding], as is **commonly practiced in developed countries**, **contributes significantly to the problem.**

To address the **discredited idea** that cesareans protect the mother from surgery later in life to treat organ prolapse or incontinence, another obstetrician wrote that: " [physicians] would **have to do 23 C-sections to prevent one such surgery** **."** [Dr. Elaine Waetjen, Ob.Gyn.News; August 1, 2002, Vol 36]

The May 2004 edition of ObGynNews noted that elective cesarean is **riskier to the newborn baby than vaginal birth**. It stated:

> "Neonates born by elective cesarean section are at **greater risk of poor outcomes than those born vaginally**.... 14% of those from the elective cesarean group (relative risk 3.58) were admitted to an advanced care nursery [in contrast with only 5% of vaginal delivery] ....oxygen was used ... in 73% of those in the elective cesarean group [compared to only 23% in vaginal delivery group]...
>
> The **difference may be due to beneficial effects of the process of labor and delivery** on infants and their ability to transition following delivery. Clinicians should consider neonatal effects, as well as maternal well-being, when discussing the possibility of elective cesarean delivery inpatients with uncomplicated pregnancies, he said." [emphasis added] (ObGynNews May 1, 2004, Vol 39, No 9)

In regard to the topic of medically unnecessary elective or 'maternal choice' cesareans, performed in a misguided attempt to reduce pelvic floor dysfunction, Dr. Peter Bernstein noted:

> There may be **no legal liability to the physician who performed the patient's first cesarean** section when the patient winds up with a **hysterectomy or worse**, but that **does not clear that physician of responsibility for performing a surgical procedure of unclear benefit** upon a patient's request.
>
> Some argue that, from an ethical point of view, allowing a patient to choose to deliver by cesarean is not substantially different from allowing her to choose to undergo cosmetic surgery. But cesarean is very different. The benefits of elective cesarean relative to vaginal delivery are not established and the risks are substantial, especially given the potential for future repeat cesareans.
>
> That women are seeking elective cesarean deliveries is probably more significant in that it **indicates the failure of modern medicine and society at large** in the sense that **women may fear the experience of labor** and **birth attendants may fear the legal risks of allowing appropriate women to have a trial of labor.**

Episiotomy -- the "unkindest cut"

The evidence *against* routine use of **episiotomy** is irrefutable -- it fails to help and it directly produces harm. It is referred by some in the medical literature as an **"injurious procedure".** According one physician-researcher, Dr. Robert Woolley, MD" "... **there are are no valid indications, maternal or fetal, for episiotomy, and therefore the only appropriate rate of its use is zero."**

In regard to a startling lack of informed consent, Dr. Woolley quotes and affirms author Shelia Kitzinger, stating that: " ... episiotomy 'is the **only surgery likely to be performed without her consent on the body of a healthy woman in Western society**' (Kitzinger 1986 Intro). It is puzzling and troubling that this is so."

Excerpts from "*Benefits and risks of episiotomy: A review of the English-language literature since 1980*" by Robert Woolley;

If we were to **adopt a more scientific view** of the evidence available on the subject of episiotomy, disclose this information to our patients, listen to their perspective, and ... choose to **heed the evidence over our prejudices**, we could hardly fail to **reduce dramatically the use of this injurious procedure**.

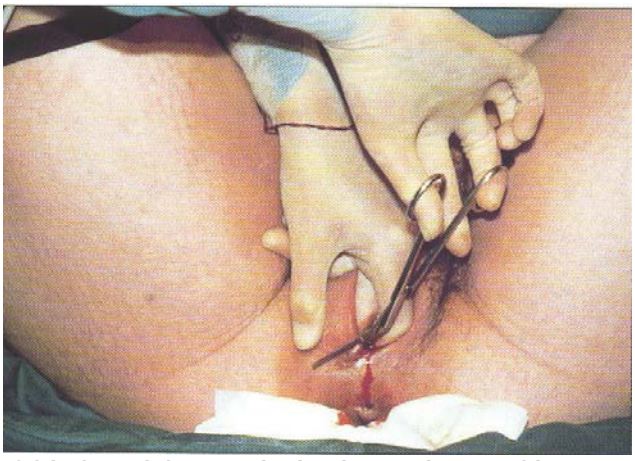
It is axiomatic in our profession that the burden of proof of the safety and efficacy of a surgical procedure falls on those who perform or advocate it. This **burden clearly has not been met for episiotomy**; its safety and efficacy had not been demonstrated **..... why has practice not changed?**

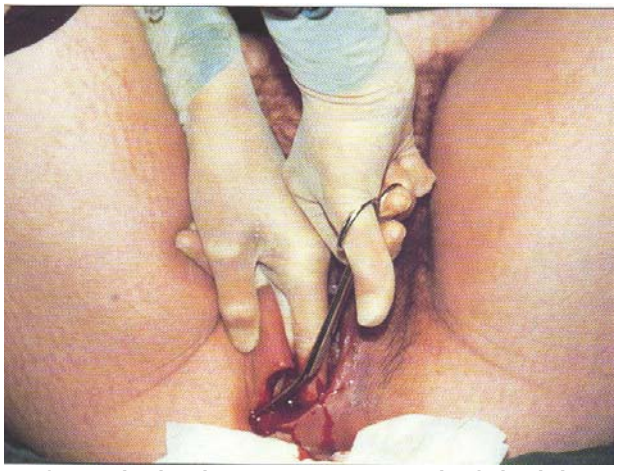
If episiotomy were a new, experimental procedure, and its initial results those described in this review, there can be no doubt that the **research would be halted and episiotomy relegated to a brief and ignominious place** in the annals of medical history.

The English-language literature published since 1980 on the **benefits and risks of episiotomy can be summarized** as follows:

Episiotomies prevent anterior perineal lacerations (which carry minimal morbidity), but **fail to accomplish any of the other** maternal or fetal **benefits traditionally ascribed**, including prevention of perineal damage and its sequelae, **prevention of pelvic floor relaxation** and its sequelae, and protection of the newborn from either intracranial hemorrhage or intrapartum asphyxia.

It is never medically necessary unless the unborn baby is distressed or if the mother is exhausted and asks for an episiotomy to shorted pushing (textbook photos of episiotomy)





1) blades of the surgical scissors inserted into vagina 2) surgical scissors create a 2-3 inch incision

In the process of affording this *one small advantage*, the incision substantially increases maternal blood loss, the average depth of posterior perineal injury, the risk of anal sphincter damage and its attendant long-term morbidity (at least for midline episiotomy), the risk of improper perineal wound healing, and the amount of pain in the first several postpartum days.

The most famous shibboleth of medicine, **"Primum non nocere" ("First, do no harm")** — that is, the assertion that the avoidance of inflicting any harm outweighs all other moral imperatives — probably has neither the historical nor the philosophical weight we tend to attribute to it [187-188]. Nevertheless, the principle of non-maleficence remains foundational to our professional ethics.

We would do well to "provide patient care in the spirit of a new aphorism, based on the concept of risk-benefit analysis: Saltem plus boni quam mali efficere conare — At least try to do more good than harm" [189]. **By either standard, episiotomy has "been weighed in the balance and found wanting"**.

Excerpts from "*Benefits and risks of episiotomy: A review of the English-language literature since 1980*".Dr. Robert Woolley, MD Part I. Obstet Gynecol Survey 1995; 50:806-820; *Benefits and risks of episiotomy: A review of the English-language literature since 1980*. Part II. Obstet Gynecol Survey 1995; 50:821-835 and unpublished manuscript circulated on Ob.Gyn.Net user group (1997)

Neonatal Consequences of Epidural Anesthesia

The newborn complications of epidural anesthesia are rarely discussed in public. However a study entitled *"Epidural, maternal fever and neonatal sepsis evaluation"* by Dr Ellice Liberman, et. al. [published Pediatrics, 1997;99:415-420] **reveals the astonishing proportion of iatrogenic complications** affecting babies that are directly related to the use of these anesthetic:

Overall, **63%** of the women (1,047) studied received epidurals, but their number accounted for **96% of those who developed fevers during labor**. Their babies accounted for around **86% of all newborns tested for sepsis** and about **87% of those given some form of antibiotics.**

This means 87% of neonatal admissions to special care nurseries for antibiotics are a direct complication of epidural use -- a huge and unnecessary financial expense added to the bill for

"normal birth" services. In addition, it appears that the body temperature of the unborn baby can be raised to dangerously high level when its mother has an epidural. According to Dr. Li

One study measuring **fetal skin temperature during labor** found that in 9% of the cases reviewed where the mother was given an epidural, fetal skin temperature reached 39 degrees centigrade [approximately **103.6 degrees F**], as compared with the non-epidural group in which no fetuses had as high a skin temperature.

They suggest that as fetal core temperature is likely to be 0.75 degrees C. [approx. 1 1/2 degrees F.] higher than fetal skin temperature, **core temperature [of the baby] may sometimes reach 40 degrees C. [approx. 105 degrees F.], a temperature that in adults is associated with heat stroke risk.**

The lead author of this study, Dr. Liaberman addresses the topic of these complication for the new baby and the need for fully informed maternal consent based on knowledge these possible complications. She says that she:

> ".... does not want to stress-out young mothers-to-be with her findings, but feels all women should have this information when deciding on an epidural."
>
> "The testing process to see if the newborns have sepsis [infections] is **extremely painful because it involves drawing vials of blood and sometimes doing a lumbar puncture [spinal tap]** to remove fluids from the infant's spine," she said. **"It can become an ordeal for the infant."**

♥ Chapter Four ~ Flat Earth Obstetrics -- a prisoner of its own project

And yet, when the obstetrical profession is presented with this corrective information, it **consistently fails to take corrective action.** It is a prisoner of its own project – the ever-expanding medicalization of normal birth based on the **discredited** notion that childbirth is a fundamentally pathological event requiring medical management and surgical delivery. In spite of the **mass of scientific literature documenting these iatrogenic complications, t**he obstetrical profession refuses to be held accountable, or even to acknowledge, the problems it systematically introduces into the care of healthy childbearing women. Instead it claims that the biology of normal childbirth

itself is intrinsically defective and that complications, such as pelvic floor damage and incontinence, are merely the 'collateral damage' of normal vaginal birth and certainly not to be associated with their interventionist management style. According to ACOG, the "smart" choice -- often referred to by obstetricians as “vaginal by-pass” surgery -- is to avoid these problems via the elective and medically unnecessary cesarean.

The problem is that physicians are the natural spokespersons for the scientific discipline of medicine. This places a societal burden of candor and accuracy on doctors by virtue of their advanced education and license to practice medicine and creates a higher standard of conduct than mere recitation of personal preference or professional self-promotion. The very fact that physicians are holders of a doctorate (a PhD) in the science of medicine gives the public **every good reason** to believe that formal statements made by physicians about matters of health, safety and medical care are unbiased, scientifically-based and factually correct. This would include a duty to communicate only scientifically valid information in a public forum unless such statements are identified as merely a personal or political opinion. As amply demonstrated by the literature, many of those with a doctorate are not living up to their obligation to speak and act on the best scientific evidence. It can be argued that licensed physicians have a legal or "due diligence" obligation to provide "honest, complete, and impartial" information in their field of expertise.

ACOG policies define the ethical responsibilities of an obstetrician giving "expert witnesses" in court as a duty to provide "honest, complete, and impartial" testimony. The American Medical Association considers the provision of "expert testimony" to be a bona fide practice of medicine; physicians giving fraudulent testimony can face disciplinary charges by their licensing boards. So far, none of these noble ideals are being applied to ACOG's public propaganda campaign, which focuses on promoting routine medicalization, elective inductions and maternal choice cesarean delivery. They pursues this self-serving agenda while actively deriding physiological management as a either substandard or dangerous form of care.

Betrayal of Trust ~ the all to familiar story of big business being unaccountable to the public

While the motives are different, the methods used by organized medicine are disturbingly similar to those used by tobacco companies, Enron, Arthur Andersen and others who abuse the public trust. The strategy depends on **asymmetrical access and control of information** combined with the popular notion that expert systems are far too complex for any layperson to understand.

Asymmetrical information means that only insiders have the full story. As insiders, they routinely conspire to conceal data and sources that do not protect or promote their own interests. In the corporate and political realm, it seems that only Martha Steward is expected to tell the whole truth all the time. Everyone else depends on the asymmetrical control of information.

Asymmetrical distribution of vital information by the obstetrical profession raises this disturbing question:

> "**Do two, carefully chosen *half-truths* equal Truth with a capital T *or* ..... is this a legal way to conceal the greater Truth while not having to tell an outright lie**?"

Unfortunately people assume that expert members of an expert system can always be counted on to be above reproach. The public places such trust in them that to most people, exerting oversight of expert systems seems both unnecessary and frankly impossible.

And yet obstetrics is an "expert" system that has **failed *most* in the very area it was supposed to have the *most* mastery and expertise** -- preserving the health of already healthy mothers and babies. As "experts" it was their duty to protecting women from the vagaries of Mother Nature *and to guard women against the unwise meddling and excesses of Modern Medicine*. Mastery in childbirth services meant bringing about a good outcome *without introducing any unnecessary harm*. An operative rate over 50% confirms that the introduction of harm has been institutionalized and thus the obstetrical profession has failed in its most basic responsibility --- "**in the first place, do no harm**."

Midwifery -- Collateral Fatality to Flat Earth Obstetrics

For the entire course of the 20th century, the obstetrical profession has distracted public attention from its unproven hypotheses of ever-escalating intervention by redirecting everyone's attention to the supposed *midwife problem*. The midwife problem was an invention of organized medicine which referred to the problem that doctors were having in getting rid of midwives.

The straightforward purpose of eliminating the practice of midwives was to commandeer normal midwife births into "clinical material" (teaching cases) for medical students. This was to rectify glaring deficiencies in medical education as identified by the *Flexner Report*, published in 1910,

which investigated why maternal and infant mortality in the U.S. was "appallingly high" compared to other developed countries. Unlike the prestigious medical schools of Europe, obstetrical education in the U.S. did not include clinical or hands-on experience at that time. The untested hypothesis by medicine school administrators was that if female midwives could do a decent job of delivering babies then doctors trained in surgery would be able to do a vastly superior job *if only they could be supplied with improved medical education*. The improvement they sought was a steady supply of teaching cases (referred to as obstetrical 'material') that was needed by medical students to “practice” operative procedures (such as use of forceps) and to hone their clinical judgment. To accomplish this ambitious goal, physicians embarked on an aggressive campaign to eliminate the profession of midwifery.

The not-so-subtle hidden agenda was to **elevate the social status of obstetrics and the income of physicians**. This was to be done by divorcing childbirth services from the low paid work of women/midwives so that a 'professional' (i.e., much higher) fee could be collected. The excuse used in public for these radical changes was that it was *unfair* to the poorer class of women, who commonly used midwives, to be deprived of anesthesia and other “benefits” of medicalized childbirth. According to the obstetrical profession, the *real* reason obstetric statistics reflected such poor outcomes was because doctors were forced to take care of all the *mistakes made by midwives*. They argued for a single standard of care -- a medically-based standard *defined by and for doctors* -- in which spontaneous childbirth was redefined as a surgical procedure that could *only* be performed by a surgically-trained specialist on an anesthetized mother in a properly equipped operating room.

For women the midwife problem was not simply that doctors, instead of midwives, were being employed to deliver babies. From the perspective of history, the *real* midwife problem was that, in order to make midwives wrong, medical politicians also had to make the entire discipline of midwifery itself wrong by **deconstructing the very foundation of normal birth**-- the philosophy and principles of physiological management. Whatever midwives did, doctors had to do just the opposite. If the discipline of midwifery related to childbirth in healthy women as a unique but nonetheless normal biological function, then obstetrics must relate to childbirth as uniformly abnormal and, when speaking of childbirth, always speak of the “danger of childbirth.”

In order to take patients--clinical material--from the thriving midwifery practices of the early 1900s, medical politicians publicly promoted the idea that obstetrician care was highly superior to that of mere midwives, claiming that the lives of mother and baby were vastly safer in the hands of doctors.

As an added inducement to the public to trade up to doctor care, it was promised that the mother would be knocked out during birth with general anesthesia and not remember anything – the original version of painless childbirth.

What started out as a midwife problem quickly became a life-threatening medical problem for childbearing women and babies. Instead of treating childbirth as a normal body process, physicians related to the care of healthy childbearing women as an opportunity to develop their skills in interventive obstetrics by routinely using chloroform, episiotomy, forceps and manual removal of the placenta at every normal birth. It is no wonder that anesthetic deaths, hemorrhage, infection, neurological injury to newborns and long-term gynecology complications for mothers followed in the wake of these ill-conceived ideas.

When mothers or babies died or were permanently damaged as a direct result of this unwise interference, the midwife problem became a crisis for the rest of society. In 1932 a physician-statistician for the Metropolitan Life Insurance Company studied the care provided and the outcome statistics for births attended by midwives from the Frontier Nursing & Midwifery Service in the Appalachian Mountains of Kentucky. In a public address he stated that if such midwifery care were generally available to the childbearing women of the United States, it would reduce the maternal/perinatal mortality by an estimated 70,000 deaths per year -- 10,000 mothers, 30,000 stillbirths and 30,000 babies that died before they were a month old. ["Into This Universe" , Alan Frank Guttmacher, MD, John Hopkins University Viking Press, 1937, Charter 4, p. 329] Despite such a stunning indictment, the obstetrical juggernaut continued.

Eliminating midwives also eliminated any useful comparison of the two different methods via analysis of vital statistics derived from birth registration records. Without data on midwife-attended births, outcomes of childbirth for healthy mothers with normal pregnancies managed by physiological principles could not be contrasted with outcomes following the use of interventionist obstetrical techniques on healthy women. By controlling the public discourse through the control and **asymmetrical distribution of information**, organized medicine ultimately came to control public opinion. Thus the profession of obstetrics also controlled the legal and legislative framework for how maternity care was configured and provided throughout the 20th century. One obstetrical spokesperson of the period (1911) summed up the all-encompassing aspirations of the obstetrical profession this way:

> We believe it to be the duty and privilege of the obstetricians of our country to safeguard the mother and child in the dangers of childbirth. **The obstetricians are the final authority to set the standard and lead the way to safety. *They alone can properly educate the medical profession, the legislators and the public.*** Boston Medical and Surgical Journal, Feb. 23, 1911, page 261

However, the price for unconscious childbirth under medical (interventionist) instead of midwifery (physiological) management was staggering – an increase in maternal mortality (15% per year, usually from sepsis or hemorrhage) and increase in neonatal birth injuries by 44% in the first decade (1910 –1920). In addition to maternal death and infant brain damage, women also suffered from pelvic floor damage such as fistulas and incontinence subsequent to the damage from episiotomy and forceps, which were routinely used on every mother who did not deliver precipitously before the doctor arrived.

♥ Chapter Five ~ Faith-based Journalism ~a lose/lose proposition

Unsafe maternity care practices have dominated obstetrics for the entire 20th century and yet have gone unnoticed, unexamined and unchallenged in the public arena. Journalists have increasingly accepted expert systems as beyond scrutiny and above reproach. This has produced ***faith-based reporting***, in which journalists never look beneath the surface. Based solely on obstetrical sources, print and broadcast media enthusiastically promote new obstetrical technologies, medical interventions, and now medically ***un****necessary* cesareans. It would be refreshing to see journalists question their questionable relationship with a faith-based reporting system and instead ask real questions of the obstetrical profession.

Considering the following, maybe, just maybe, normal or 'physiological management' by doctors and midwives as the acknowledged standard for healthy women is an idea worth exploring:

- maternity care is 20% of the national health care budget,
- that 40% of all births are paid for by the federal Medicaid program,
- that many state governments are facing huge budget deficients,
- that bio-chemical terrorism would overwhelm our current interventionist and drug intensive obstetrical system --

The *real question* for journalists is why the majority of childbearing women do not receive the safer, cost-effective and non-interventive type of care established as beneficial in the *Guide to Effective Care in Pregnancy and Childbirth (synoptic version of third edition)* and recommended by the highly respected Maternity Center Association of NYC. The beneficial practices identified by the *Guide to Effective Care* are protective and reduce medical and surgical interventions and yet they are **absent for the majority of women** giving birth in this country under obstetrical management.

The challenge for the 21st century is to bring about a fundamental **restructuring of maternity care** in the United States. This is an economic as well as a humanitarian issue. Worldwide, the global economy depends on the use of physiological principles and low-tech, inexpensive methods of midwifery care for normal birth services to retain its competitive edge. The US must also utilize these safe and cost-effective forms of care in order to compete in a global economy. **In the US the social model of childbirth,** which depends squarely on physiological management for its success in providing care to healthy women with normal pregnancies, **must become the foremost standard of care.** At least 70% of the childbearing population is healthy and have normal pregnancies.

Under this system, management strategies would be determined by the *health status of the childbearing woman and her unborn baby* in conjunction with the mother's stated preferences, rather than by the *occupational status of the care provider* (physician, obstetrician, midwife). At present, *who* the woman seeks care *from* (doctor vs. midwife) determines *how* she is cared for. Currently our tort laws force doctors to provide interventionist care irrespective of the health status of the mother, or of her wishes. It should be noted that this creates an asymmetrical burden of risk that falls unfairly on the childbearing woman, in which the mother is exposed to the actual pain and potential harm of medical and surgical interventions in order to *reduce the risk of lawsuits for the obstetrician*. This is unacceptable.

The unexamined theory of our tort laws induce physicians to protect themselves by 'cost-shifting', 'risk-shifting' and 'blame shifting'. This is particularly pernicious when surgical "solutions" are implemented by obstetricians in order to reduce the legal culpability to themselves, as physicians are *not legally responsible for post operative complications.* For instance, physicians are expressly exonerated liability for "downstream" sequelae or time-delayed complications such as future incontinence (the sequelae of forceps delivery) or placenta percreta in a future pregnancy (the sequelae of Cesarean section). Dr. Peter Bernstein made this observation earlier when he note that

the law (and at present the ethical designation by society) *inappropriately protects the physician* who chooses to reduce the litigious risk to himself by shifting it forward to the mother and/or baby in a future pregnancy. According to Dr. Bernstein:

> There may be **no legal liability to the physician who performed the patient's first cesarean** section when the patient winds up with a **hysterectomy or worse**, but that **does not clear that physician of responsibility for performing a surgical procedure of unclear benefit**....

In the short term, the most direct remedy to this problem is truly transparent informed consent for the use of interventive and operative obstetrics. In the long term it requires the rehabilitation of two important areas of modern life --our tort laws and of our maternity care system.

In a rehabilitated maternity care system, physicians who provide care to a healthy population would be required to either utilize the successful strategies of physiological management themselves, cede the care of healthy women to those who do, or obtain truly informed consent for substituting medicalized obstetrical care with its well-documented dangers. Fully informed consent would require true informational transparency relative to the documented consequences of medicalized labor and normal birth conducted as a surgical procedure.

Scientifically correct information must be **routinely provided on the limitations and problems associated with the medicalization of labor** – i.e., drugs, anesthesia, and medical interventions and procedures that abnormally limit mobility or confine the laboring women to bed. This severely limits or eliminates access to time-tested strategies of physiological management and right use of gravity, thus increasing artificial stimulation of labor and operative delivery and all their associated complications.

Obstetricians must provide valid information during the last trimester of pregnancy that includes the short and long term complications associated with major medical and surgical procedures performed during the labor – continuous electronic fetal monitoring, restriction of oral nourishment, IVs, labor stimulating/inducing drugs, off-label use of drugs (ex. Cytotec), narcotic medication, epidural anesthesia, indwelling bladder catheters, episiotomy, vacuum extraction, forceps and a 26% cesarean section rate. The benchmark for this transparency should be the same information about complications that is reported to physicians in the scientific literature and

obstetrical trade papers, such as *Ob.Gyn.News.* This should be faithfully restated for childbearing parents in lay terms that are appropriate for their concerns.

Electronic Fetal Monitoring ~ Institutionalized failure as an art form

In particular, obstetricians must identify the lavishly-documented failure of continuous electronic fetal monitoring and liberal use of cesarean section to reduce the rate of cerebral palsy and other neurological disabilities. Most people wrongly assume that EFM is the equivalent of an electrocardiogram (EKG) for the unborn baby but this is a serious misunderstanding of the technology. Electronic monitoring is simply **an elaborate mechanism to count the pulse** of the unborn baby. The machine merely transposes the acoustic signal of heart rate into a printed paper graph and video display, which makes the four auditory markers of fetal well-being visible. The use of an acoustical fetascope or an electronic doptone can provide the same on-going data (same four markers) on the well-being of the unborn baby without the interpretive errors, physical restrictions and unrealistic expectations associated with the use of continuous EFM.

In July of 2003, a report by the *ACOG Task Force on Neonatal Encephalopathy & Cerebral Palsy* stated that*:*

> **Since the advent of fetal heart rate monitoring, there has been no change in the incidence of cerebral palsy.**" "... The majority of newborn brain injury **does not occur during labor and delivery.** Instead, most instances of neonatal encephalopathy and cerebral palsy are **attributed to events that occur prior to the onset of labor.**

This report had the endorsement and support of six major federal agencies and professional organizations, including the Center for Disease Control & Prevention (CDC), the March of Dimes and the obstetrical professions in Australia, New Zealand and Canada. It is described as the "most extensive peer-reviewed document on the subject published to date."

An August 15, 2002 report on this topic in *Ob.Gyn.News* stated that

> **… performing cesarean section for abnormal fetal heart rate pattern in an effort to prevent cerebral palsy is likely to cause as least as many bad outcomes as it prevents."** ... A physician would have to **perform 500 C-sections** for multiple late decelerations or reduced beat-to-beat variability to **prevent a single case of cerebral palsy**."

The September 15, 2003 edition of *Ob.Gyn.News* stated that:

> **The increasing cesarean delivery rate that occurred in conjunction with fetal monitoring has *not* been shown to be associated with *any reduction* in the CP rate**..." " **...** Only 0.19% of all those in the study had a non-reassuring fetal heart rate pattern.... **If used for identifying CP risk, a non-reassuring heart rate pattern would have had a 99.8% false positive rate....**

Despite a success rate of only 00.2%, most hospitals bill around $400 an hour for continuous EFM. Regularly listening to fetal heart tones with an electronic Doppler for one full minute immediately after a contraction, (called **Intermittent auscultation** or 'IA') permits the same data on the four auditory markers of fetal well-being (baseline heart rate, variability, accelerations and absence of pathological decelerations) to be obtained.

While intermittent auscultation is more time-intensive, IA for low and moderate-risk labors is equally as effective as continuous EFM, with the added benefit of a greatly reduced cesarean rate (4% vs. 26%). This is, in part, because it *unhooks* healthy mothers from machines and permits laboring women to move around freely. No longer tethered to the bed by electronic wires, the mother is able to change positions frequently, walk, use hot showers or deep water for pain relief and make "right use of gravity" These practices reduce fetal distress and the need for Pitocin-augmentation of labor, pain medication, anesthesia and instrumental and operative delivery.

Obstetricians need to acknowledge this domino effect, also called the *cascade of interventions*, associated with highly medicalized childbirth. This cascade occurs when procedures, such as induction of labor, trigger the need for other interventions, such as continuous EFM and epidural anesthesia. The cascade of interventions can so disturb the biological process that it can in turn lead to fetal distress or operative interventions.

Cesarean section is the ultimate operative intervention and is associated with a peripartal emergency hysterectomy rate 13 times greater than vaginal birth. Other common surgical interventions such as episiotomy, forceps and vacuum extraction are strongly associated with pelvic organ dysfunction and maternal incontinence after the birth. These pelvic floor problems are not, as some obstetricians claim, merely collateral damage of normal birth but are the predictable consequence of a failure to make right use of physiological principles, especially spontaneous labor and the right use of gravity.

Medical journals make it clear to all that routine obstetrical interventions and birth as a surgical procedure for healthy women are **always more dangerous** than the use of physiological principles in conjunction with appropriate social and psychological support. Scientifically-speaking, this is *not* a controversial finding. Reliable scientific evidence is neither lacking nor incomplete, nor is this data the subject of methodological disputes.

Consider this: If planes landing at US airports *crashed five times more often than when they landed at airports in England or Japan*, we would demand an inquiry of our air traffic control system, since the laws of aerodynamics are the same worldwide. Each year in the US about 8 million mothers and babies 'fly' ACOG's united service of interventionist obstetrics. Only a fraction -- under 30% -- need and benefit from this type of medicalized treatment. Isn't it time to inquire why the universal "laws of normal childbirth", which are the same worldwide, are being routinely suspended by American obstetricians and, as a result, American mothers and babies are crash landing at an alarming rate.

♥ Chapter Six ~ How to Make the System work for everyone

The main and the plain reading of the scientific literature brings one to the logical conclusion that **physiological management is the safer and most cost-effective form of care for a healthy population**. This leads us to the natural and compelling conclusion that our current hospital-based maternity care system must be rehabilitated.

A **newly formulated national health care policy would integrate physiological principles with the best advances in obstetrical medicine to create a single, evidence-based standard for all healthy women.** That standard must be based on criteria arrived at through an **interdisciplinary process** that **INCLUDES** the traditional **discipline of midwifery** as an independent profession and integrates the **input of childbearing women and their families** into the process. It is especially important to include testimony from those families who had complications following cesarean surgery or who found it virtually impossible to arrange for a subsequent normal labor and birth after a cesarean (VBAC).

Such a transformation in our national maternity care policy would require that:

- **Medical educators learn and teach the principles of physiological management** to medical students, interns and residents
- **Practicing physicians learn and utilize these same skills**
- **Fully informed consent for obstetrical management of healthy women be provided that includes true informational transparency** relative to the documented consequences of medicalized labor and normal birth conducted as a surgical procedure.
- **Hospital labor & delivery units be primarily staffed by professional midwives,** with incentives for current L&D nurses who wish to retrain for hospital-based midwifery practice to do so at minimal expense to themselves
- **Third party payers fairly reimburse all practitioners for the professional's time spent facilitating normal childbirth**, which helps avoid the need for medical and surgical intervention, as well as reimbursing for medical and surgical procedures
- **Tort law (medical malpractice) reform be enacted so that doctors are not inappropriately judged by outdated medical criteria that are not evidence-based**

In a rehabilitated maternity care system, professional midwives, family practice physicians and obstetricians would all enjoy a mutually respectful, non-controversial relationship. Appropriate maternity care would be provided by all three categories of professionals in all three birth settings as appropriate – hospital, home and birth center – without prejudice, controversy or retaliation against the childbearing family or against other care providers. By making maternity care in all settings equally safe and equally satisfactory, families would not be forced to submit to forms of care that are not appropriate for their needs or that waste our economic resources.

This rehabilitative process could be launched by the California state legislature or a public policy organization such as the Pew Charitable Trust which could convene a **blue-ribbon panel consisting of scientists from all the pertinent disciplines** – public health, epidemiology, sociology, anthropology, psychology, biology, child development, law, economics, midwifery, perinatology and obstetrics. Such a highly respected forum would study these problems and provide unbiased, fact-based news for the press and broadcast media to report. This public exploration must include listening to childbearing women and their families as a class of experts in the maternity experience.

Such a panel would produce interdisciplinary recommendations for a reformed national maternity care policy. This would include methods to reintegrate midwifery principles and practice into this expanded system of maternity care. Ultimately such exploration and recommendations would result in legal and legislative changes affecting doctors, hospitals, midwives and the health insurance industry. Such a system would then be **respected and used equally by all maternity care**

providers with the backing of hospitals, health insurance and medical malpractice carriers, and state and federal reimbursement systems (Medicaid / MediCal) etc**.**

In Conclusion: Only by **returning the philosophy and physiological principles of normal childbearing to their rightful and central place** in our national maternity care policy can our healthcare system economically **meet the needs of our own childbearing population while remaining competitive in the global economy of a 21st century world.**

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Recommended Reading: Editorial ~ Home Delivery – Why? By Michael Fleming, MD, Assistant Professor, Department of Family Medicine, School Medicine, University of North Carolina, Chapel Hill. This editorial gives an excellent perspective by a family practice physician on why and how to employ physiological principles in hospital-based obstetrical practice, including the full-time presence of the primary caregiver during active labor (also see "Physiologically-sound practices" immediately below)

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Stedman's Medical Dictionary definition of **"physiological" – "…in accord with, or characteristic of, the normal functioning of a living organism" (1995)**

♥ Physiologically-sound practices** include:

Continuity of care
Patience with nature
Social and emotional support
Mother- controlled environment
Provision for appropriate psychological privacy
Mother-directed activities, positions & postures for labor & birth
Full-time presence of the primary caregiver during active labor
Recognition of the sexual nature of spontaneous labor
Upright and mobile mother during active labor
Non-pharmaceutical pain management such as showers & deep water tubs
Judicious use of drugs and anesthesia when needed

Absence of arbitrary time limits as long reasonable progress, mom & babe OK

Vertical postures, pelvic mobility and the right use of gravity for pushing

Birth position by maternal choice unless medical factors require otherwise

Mother-Directed Pushing / NO Valsalva Maneuver (prolonged breath-holding)

Physiological clamping/cutting of umbilical cord-- after circulation has stopped (average 2 to 5 minutes)

Immediate possession and control of newborn by mother and father

On-going & unified care and support of the mother-baby for postpartum

Access to appropriate care for the 'Second Nine Months' -- breastfeeding advise, infant development, parenting and psychological adjustments to postpartum stresses relative to other children, spouse and employment outside the home, etc

** A fundamental principle of the social model of maternity care is the decision-making autonomy of the parents and **the right of mentally competent childbearing women to have control over the manner and circumstance of normal labor and birth**.

The right to be self-directed and to decline any and all interventions **extends to any of specific practices of physiological management listed above** that an individual laboring woman may object to. This encompasses the right to choose medical and surgical interventions, including elective cesarean delivery, if she so desires.

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Another way to access the scientific documentation is the navigational hyperlink to "Scientific Literature", which is in the list on top left side of the index page of the CEO site. Other research supportive of the material published on the CEO website are the Maternity Center Association's publication "**Listening to Mothers**" and **"What Every Pregnant Woman Needs to Know About Cesareans".** We strongly recommend down-loading PDF copies of these and the other excellent documents on evidence-based maternity care available at www.maternityWise.org