Where We Were

To understand where we are now, we must first jump into our Wayback Machine and see where we were in 1980. The shift to high-tech labor management was in full swing. The cesarean surgery rate had reached the shocking high of 15%—high enough that the National Institutes of Health convened a consensus conference on how to bring it down. Vaginal Birth After Cesarean (VBAC) was rare, making repeat cesarean one of the soaring rate’s main drivers. Epidural anesthesia for labor was burgeoning, and as hospitals began installing dedicated obstetric anesthesia services, the need to recoup their costs soon became pressure to have one. Likewise, routine continuous electronic fetal monitoring (cardiotocography) was rapidly becoming the norm. Episiotomy was routine, but progressive practitioners were questioning it, and the first randomized controlled trials would begin appearing mid-decade. Klaus and Kennell’s landmark bonding research hadn’t had much impact, and babies were typically removed to the nursery shortly after delivery. Few nurses knew much about breastfeeding, and babies of breastfeeding moms were commonly given bottles of sugar water or formula, and pacifiers. Rooming in was rare.

Some hospitals were opening “Family Birth Rooms” (FBRs) or “Alternative Birth Centers” (ABCs). Theoretically, they were supposed to provide a more natural childbirth experience in a home-like environment for low-risk women who desired it. Their main advantage was that women could labor, give birth, and recover with their babies without being moved from place-to-place. In actuality few women got to use them, many who did risked out during labor, and care mostly amounted to Polly Perez’s analogy to designer jeans: “Fancy new label, same old jeans”.

Some petunias had sprouted in this increasingly medicalized potato patch. The appearance of freestanding birth centers was one. Another was the increasing use of nurse-midwives, mostly as employees of private obstetricians or hospitals serving low-income women. Independent practice was difficult as they were often denied hospital privileges. The concept of having an experienced woman to provide continuous 1:1 labor support had also poked its head above ground. I use “experienced” rather than “trained” because there were as yet no wide-spread, formal training programs or agreement on scope of practice or even on what such a person should be called. Eventually, consensus settled on “doula” with a job description restricted to providing emotional and physical supportive care and advocacy. Doulas worked mostly in stealth mode. Hospital staff generally had no idea they weren’t simply a family member or friend.

Childbirth education stood at a crossroads. It arose in the 1960s on the principles that laboring women had the right to labor with a loved one by their side to comfort and assist them and to be awake and aware if they wished to be. This was an easy sell. By the early 1980s, most middle- to high-income white, married women and their husbands took “Lamaze” classes, which had become the generic term for childbirth preparation classes. Classes lasted a couple of hours or more on a once-a-week basis over six to eight weeks. Now childbirth educators had to contend with a new message: OBs and the media were promising women that Electronic Fetal Monitoring (EFM) and liberal use of cesareans averted fetal death and brain damage and that epidurals were a free pass out from unendurable pain. The doctor will almost always win a face-off with a mere childbirth educator saying those promises were false—and that’s assuming the woman even hears the other side of the debate. More and more couples were taking classes at the hospital, many of which simply prepared them to be good patients.

Still, not every woman in this category bought in. Aided by such books as the *Immaculate Deception*, *Spiritual Midwifery*, and *Silent Knife*, women wanting what we now term “physiologic birth” sought out Bradley classes, hired doulas, and chose home or birth center birth attended by mostly direct-entry midwives in the former case and mostly nurse-midwives in the latter. Unlike nurse-midwifery, direct-entry midwifery was not organized, had no agreed-upon training standards, and its practice was either explicitly illegal or in a legally gray area in almost all states.

Other women had learned to their sorrow that they
had been sold a bill of goods. They banded together to form grassroots maternity-care reform organizations. While the broader reform movement was toward less interventive care, access to VBAC was a specific focus. The Cesarean Prevention Movement (CPM), founded in that era, survives to this day as the International Cesarean Awareness Network (ICAN). BirthWorks itself began under the auspices of CPM to train childbirth educators to teach women how to avoid the first cesarean. Agitation had some effect. It led, among other things, to the opening of the FBRs and ABCs mentioned above and to a rise in the number of VBACs. Even so, as noted, hospital birthing rooms were mostly window dressing, and the vast majority of women continued to have automatic repeat cesareans.

As for my special interest, the research, what little there was of it, supported physiologic care. Not that it mattered. The concept of evidence-based medicine was still in its infancy, and collective opinion still ruled, especially in obstetrics, so the research didn’t cut much ice.

Where Are We Now? “It Is the Best of Times; It Is the Worst of Times.”

Now that you have the back story, we can turn to where we are now. This can be summed up in a series of good news/bad news or, if you prefer, clouds/silver linings statements:

The cesarean rate rode the rollercoaster up to 25%, back down to 20%, mostly thanks to the increasing VBAC rate, and then, after the American Congress of Obstetricians and Gynecologists (ACOG) did a 180 on VBAC, it sailed past its former high to 32%, where it has topped out for the past few years. Rates have risen as well for first cesareans, hitting first-time mothers especially hard. As of 2013, the rate for low-risk first-time mothers was 27%. The silver lining in this cloud is that even ACOG now acknowledges that the cesarean rate is too high. It has issued a joint report with the fetal medicine doctors recommending ways to reduce first cesareans. ACOG has also issued revised VBAC guidelines that are more supportive of VBAC, although its effect on the VBAC rate remains to be seen.

For several decades now, hospital labor management in most hospitals has been organized around the assumptions that a large percentage of women will be induced, most of the rest will have labor augmented, all will be tethered to their beds by monitoring equipment tracked from a central nursing station, and all but a few hold-outs will have an epidural. As a result, many doctors and nurses may never have seen a labor and birth free of medical intervention and have no idea that what they see isn’t normal. Some changes for the better have happened, at least with some providers in some hospitals. These include the push to delay elective inductions and cesareans until 39 completed weeks (yeah, I know it’s not much, but it’s something); the steep decline in episiotomy; the growing awareness that it’s a bad idea to clamp the umbilical cord immediately (see article on page 10); more early contact with the baby, at least for women birthing vaginally; more rooming in with the baby; and better breastfeeding support.

The FBRs and ABCs of yesteryear have been reincarnated as Labor & Delivery Rooms. They make no pretense at being anything other than business as usual; still, they are a more pleasant and comfortable environment than the old style labor rooms, and thanks to specialized beds that convert to delivery tables, women delivering vaginally don’t have to be moved in the throes of giving birth.

Doulas are now on the radar screen, although this isn’t always a good thing. They may be regarded with suspicion, if not outright hostility, because of their perceived potential to influence women to want something other than what the institution provides. This isn’t always the case, of course, and for those who can afford them, they can act as a buffer against what all too often can be a lonely and frightening experience.

Nurse-midwives enjoy increased acceptance, but this silver lining comes with a cloud. Nurses who view midwifery as nothing more than an advanced practice option rather than a commitment to a model of care and midwives who are constrained by hospital policies or doctor supervision may be reduced to “med-wives” with little or nothing to distinguish their care.

The mandate to practice evidence-based care has led to what Phil Hall, an obstetrician as witty as he was wise, termed “decision-based evidence making.” Deeply flawed studies and reviews that claim to provide support for such things as elective induction, routine cesarean for breech, the dangers of home birth, even equivalency between elective first cesarean and planned vaginal birth now pepper the research literature and are cited in support of medical-model management. Back in the ‘80s and ‘90s, the argument was between opinion and research. Now it’s between my analysis and interpretation versus theirs, a much more difficult case to make to the public—which isn’t to say it can’t be done.

The fight for the hearts and minds of pregnant women has grown increasingly difficult. Women of childbearing age today have grown up in an era of high cesarean rates and highly interventive labor management. This was the experience of their mothers, their friends,
and what they see on birth reality programs. It seems quite normal to them. They believe right along with their doctors that safety lies in high-tech management and satisfaction depends on having an epidural. Mainstream childbirth preparation has been reduced to a few weekend hours spent learning a bit about the labor process and some things to do until they can get their epidural. Still, legacy methods have evolved with the times, as Lamaze's campaign promoting healthy birth attests, and newer methods, such as hypnosis for birth, have sprung up alongside.

The internet is the wild card in the deck. It allows misinformation to travel further, faster, and the public has no metric to separate the good from the bad because misinformation often comes from credible sources. On the other hand, the internet allows unprecedented access to both the public and the media to vast amounts of information that makes the case for our side. It also enables maternity care reform organizations and individuals to get out their message, and it brings together like-minded people at little or no cost.

Looking at the big picture, a number of forces converge to maintain the current system. Fear of liability is most frequently cited in this regard, but it isn’t the only factor. Perverse economic incentives reward labor induction, epidurals, and cesarean surgery, especially planned cesareans. Beliefs about the inherent dangers of labor and the need for routine intervention reinforce each other. In a vicious circle, intervention begets harms, which beget the need for further intervention, and all will be attributed to the propensity for the process to go wrong rather than the rightful cause. No silver linings here other than, perhaps, that pressures to reduce health care costs could alter the economic incentives.

Furthermore, these forces have another, even darker consequence. They lead to a belief that medical staff have the right, even the obligation, to obtain compliance. In furtherance of that goal, staff may give incomplete, no, or misinformation; perform procedures or give medication without seeking consent; threaten and bully women; or proceed despite the woman’s express refusal. Many hospitals operate within a culture of impunity. No adverse consequences follow for violating patient rights either within or from outside the institution. The legal system offers no redress, and may, in fact, be called in on the side of the perpetrators. The silver lining here is that this has ignited a new wave of grass roots reformers, and unlike the women of the previous waves, this generation is better armed because women bring their professional skills into the battle.

Saving the best news for last, we now have an infrastructure for providers of physiologic care. The intervening decades have seen the founding of certifying and accrediting bodies for direct-entry midwives, schools that train direct-entry midwives, and freestanding birth centers as well as doulas and lactation consultants, all of which enhances quality of care and credibility. All, too, have membership organizations, which enables speaking with a unified voice and collaborating on joint projects. Perhaps the most exciting of these is a coalition of nurse- and direct-entry midwifery organizations, factions that have not always played well together in the past, and another that has brought together all the stakeholders to find common ground around home birth.

Finally, nurse- and direct-entry midwives have gotten political. Their organizations now lobby at state and national levels. As a result, direct-entry midwives are now legal in many states with more hopefully coming online.

Where Do We Go from Here?

The ship has traveled a long distance in the wrong direction, and its engines continue to drive it on its course. Turning it around will take time and a Herculean, many-pronged effort. This doesn't mean that we shouldn’t try, but expecting too much too quickly is a recipe for burnout. My advice? Choose your own adventure. Figure out what best suits your passion and interests and fits with your other needs and obligations. In the words of one of the great rabbinic sages: “You are not obliged to complete the task. Neither may you cease from it”. (Pirke Avot 2:21).

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