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Independent Childbirth

9 December 2008

Home Birth: The Gold Standard of Cesarean Prevention

While home birth is stereotyped as dangerous because of the lack of medical supervision, it is the lack of that technology and medicine that actually makes birth at home safer than birth in a hospital under today's protocols. Studies have shown that once a technology is introduced and mandated, it is difficult to remove it from care practice despite being proven unsafe or unnecessary. For instance, although the rates involving an episiotomy (cutting the perineum to create a larger opening for the baby to pass through) have dropped drastically since 1980, it is still a common practice. Ironically, episiotomy rates today are justified as integral to the higher use of vacuum-assisted deliveries or unfounded fears that a baby is stuck because it is a large baby or presenting in a less than optimal position, (posteriors, for example, where a baby faces away from the mother's back during labor).

America is one of the few nations where birth is managed more with technology than with the hands and eyes of the care provider. In a country that boasts technology superior to other developed nations and is not known for undernourishing its citizens, our mothers and babies are faring no better at birth than underdeveloped nations such as Croatia. No improvements have been made in the maternal mortality rate in America since 1982, and America's infant mortality rate in the past two decades also has not improved. Our birth technology has increased and the number of routine prenatal screening tests have multiplied since the early 1960s, but our maternal and fetal outcomes have gone progressively backward.

The American College of Obstetricians and Gynecologists (ACOG), America's leading organization promoting the benefits of clinical obstetrics in the sterile rooms of trained physicians, has found itself in a dilemma. The technology and protocols ACOG promotes are the very ones that directly influence our birth statistics negatively. The birth technology ACOG promotes to prevent or lower risks in birth for both mothers and their babies has not been proven to be beneficial, yet it is used profusely. Birth in America rarely includes the intimacy of the act that culminated in procreation. Images of an infant gently caught into its own mother's arms are so rare that they cause the general public to question the safety of such an event. Debate for and against the licensing of midwifery - and the definition of midwifery itself - is gaining momentum, because statistics for hands off care of normal, natural childbirth are far better than those of managed birth.

"Despite a significant improvement in the U.S. maternal mortality ratio since the early 1900s, it still represents a substantial and frustrating burden, particularly given the fact that - essentially - no progress has been made in most U.S. states since 1982. Additionally, the U.S. Centers for Disease Control and Prevention has stated that most cases are probably preventable." states C.T. Lang in a 2008 obstetrics and gynecology report. Further, the Centers for Disease Control (CDC) reported in 1983 that the maternal mortality rate in the U.S. was 8.0 for every 100,000 live births (Monthly Vital Statistics Report). In 1993, the rate was 12.0/100,000 live births (CDC). Among the causal deaths that could be prevented were those that involve both underlying health issues such as poor nutrition and high blood pressure (World Health Organization) as well as those that are physician-caused including, infection and hemorrhage. Bacterium can be introduced first by the mother arriving in an environment where diseases are being treated as well as from infiltrating the natural barriers we have against infection through vaginal exams and, of course, surgical delivery. In addition, there are higher incidences of hemorrhage from forced delivery of the placenta as when a care provider intentionally pulls on an umbilical cord to tear the placenta away from the uterine wall of the mother's womb. In all instances, normal birth evidence training of the professional birth attendant is critical. Injuries and deaths related to the physician's care range from the off-label use of medicine such as Cytotec (also known as Misoprostol) for the inducing of labor as well as the sanctified use of surgical delivery, which gives us embolism, one of the leading causes of maternal mortality and a risk directly associated with cesareans. Cesarean rates for delivery rose by 46 percent from 1995 to 2006.

In the arena of preventing low birth weight, a health objective that unites all factions of infant health and mortality, U.S. care protocols are proven to be questionable at best and irresponsible at worst. Ricciotti et al tells us that research can prove which maternal care protocols can actually show efficacy and provides extensive statistics from research databases. They review several common birth care protocols for the prevention of low birth weight, a birth issue all activists agree needs to be improved in America. Their conclusion provides the data for proving a stringent set of criteria that needs to be developed and which technology must meet before it is utilized on mothers and their babies. Ricciotti, Chen and Sachs write "While it is difficult to determine what proportion of pre-term births might be prevented by obstetric technology, it is possible to evaluate these technologies to determine which of them might actually improve birth outcomes." These authors culled data and research on the following protocols related to the prevention of low birth weight. As they point out, the results on every one are similar. Highlighted here are the six most commonly implemented practices used in normal pregnancies as well and the results they cite:

- *Tocolytic Drugs*: These are drugs used to stop pre-term labor ~ betamimetics, inhibitors of prostaglandin synthesis, mag sulfate, calcium antagonists, combinations of the previous and/or oxytocin analogues. There is no evidence they are effective and use of these drugs associated with many potentially severe effects. Moreover, "scientific evidence of efficacy available for all of these drugs is surprisingly scarce given the frequency of their use."

- *Steroid Use to Accelerate Fetal Lung Maturation*: Evidence of a reduction in respiratory distress syndrome and subsequent neonatal mortality when given one to seven days prior to delivery; obstetricians are not appreciative of the effects as they occur after the birth, at which point the baby is under the care of another medical field.

- *Bed Rest for Twins*: Trials have excluded those that are at risk, i.e. women with bleeding during pregnancy, PIH, polyhydramnios, previous cervical cerclage or previous cesarean. For those that are actually healthy and low-risk, there may be a decrease in the incidence of developing Pregnancy Induced Hypertension (PIH) although no evidence was found that pregnancies were prolonged. Twins account for 1 percent of pregnancies but 10 percent of all perinatal deaths; therefore, it is surmised bed rest is simply routinely advised without clear evidence of any benefits.

- *Cesarean Delivery*: No evidence showing improved outcome for vertex presentations. For breech delivery, it cannot be determined if the results are “due to the intervention or the way the women were selected to undergo a cesarean or a vaginal delivery.”

- *Episiotomy*: No data demonstrating improvement in neonatal outcomes.

- *Forceps*: No benefit; increases the incidence of brain hemorrhages.

Ricciotti, Chen and Sachs conclude, “The reasons physicians use unproven technology or ignore proven ones is unclear. At present there is no easy and effective way to modify physician behavior ... it is difficult to remove familiar technologies before they are proven to be effective ... in the current climate of cost consciousness, it is imperative that the widespread use of these unproven and ineffective technologies be abandoned and the use of proven technologies be encouraged. In addition, we must be careful not to use technology in those situations where it does not improve outcomes. Dissemination of technology into low-risk populations has the potential to do more harm than good. Finally, physicians need to be educated to be wise consumers of medical technologies.”

The U.S. Public Health Service 1990 Objective for maternal outcomes is to improve the maternal death rate to no more than 5/100,000 live births. In order to begin to understand the magnitude of sorting out the possibility of achieving this goal, we must clarify the controversy surrounding the reporting of the maternal mortality rates (MMR) and neonatal mortality rates (NMR). First, we need accurate and complete data on maternal and infant deaths in order to formulate a credible plan to posit. Medically managed birth advocates argue that the definition of maternal and infant mortality differs in various countries. The World Health Organization defines a maternal mortality as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes." Even if the definition were uniform for all countries, the U.S. would retain its dismal ranking , if not drop lower. Research shows that U.S. birth certificates misclassify birth outcomes based on errors other than definition (CDC); a case likely could be made, based on this inquiry and others similar, that the errors in our country's case are actually already serving to favor the U.S. mortality rate. For the same period that we stated, the CDC reported the MMR in 1983 as 8.0/100,000. The inquiry into the misclassification on birth certificates from 1977 to 1984 shows the rate actually to be 10.9/100,000, a difference of almost 3 percent. The CDC finds that the problem persists into 1996, stating, "In this report, maternal mortality ratios are based solely on vital statistics data and are underestimates because of misclassification. The number of deaths attributed to pregnancy and its complications is estimated to be 1.3 to three times that reported in vital statistics records. Mis-classification of maternal deaths occurs when the cause of death on the death certificate does not reflect the relation between a woman's pregnancy and her death. In addition, the inclusion of deaths causally related to pregnancy that occur between 43 and 365 days post-pregnancy can increase the number of maternal deaths identified by 5-10 percent (Pregnancy related mortality in the United States)." Claims by medical birth care providers that the data is difficult to validate are unfounded. In fact, it only involves a commitment as an investigation is time intensive, but feasible. The Office of Family

Health of the New York City Department of Health used "computerized searches of hospital discharge and autopsy record databases were conducted for maternal deaths occurring in 1997." Subsequently, what it found in its research published in 2002 was "existing databases can be used relatively easily to augment routine surveillance of maternal mortality." The department uncovered the following errors for 1997 in New York City: "Active surveillance revealed 14 new maternal deaths not previously reported, an 88 percent increase. Nine of these deaths were found through the hospital discharge database search, 1 was found through the autopsy record search, and 4 were found in both searches. Overall maternal mortality ratios associated with active surveillance and routine surveillance were 24.3 and 13.0 deaths per 100 000 live births, respectively."

The ability to compile statistics on home births alone face the obstacles of historical suppression of midwifery in the form of bias and persecution today by various medical examining boards. Faith Gibson, Lay Midwife, Certified Practicing Midwife and Community Midwife researched this issue and published her research on "the official plan to eliminate the midwife" in 2006.

Gibson uncovers the following from a testimonial by Zeigler, MD, "The Elimination of the Midwife" to his peers,

> "*In all but a few medical schools, the students deliver no cases in a hospital under supervision, receive but little even in the way of demonstrations on women in labor and are sent into out-patient departments to deliver, at most, but a half dozen cases. When we recall that abroad the midwives are required to deliver in a hospital at least 20 cases under the most careful supervision and instruction before being allowed to practice, it is evident that the training of medical students in obstetrics in this country is a farce and a disgrace. It is then perfectly plain that the midwife cases, in large part at least, are necessary for the proper*

training of medical students. If for no other reason, this one alone is sufficient to justify the elimination of a large number of midwives, since the standard of obstetrical teaching and practice can never be raised without giving better training to physicians." [1912-B, p.226] {*emphasis added*}"

To improve birth outcomes for both mothers and babies, we must take a closer look at the image of a mother reaching down to catch her own baby as the newborn emerges from her body. Modern midwifery care removes physician-grown fear and instead is "based on the fact that pregnancy and birth are normal life processes" (Citizens for Midwifery) and whose basic principles are guided by the Midwifery Model of Care$_{TM}$: "Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, and prenatal care; continuous hands-on assistance during labor and delivery, and postpartum support; minimizing technological interventions; identifying and referring women who require obstetrical attention."

Midwives rely on expert use of their hands and communication skills to personalize the care they provide mothers. These are skills medically-minded professionals lack because they allow technology to stand between them and the female body. It is well-documented that external fetal monitoring is done for the benefit of the labor-and-delivery nurse who can leave the room and monitor from the nurse's station. The labor-and-delivery nurse is also a gatekeeper between mother and doctor until such time as the nurse deems the obstetrician should make their way to the hospital as late active labor and imminent birth are determined.

The more a midwife speaks to a mother and spends quality time with her, the more likely a mother is to open up and reveal more of her daily routines and habits that can affect her pregnancy and birth. For example, the midwife will ask a mother the most basic yet critical questions (what is she eating?) and follow up with nutritional counseling, a topic in which the midwife owns expertise. The average obstetrical course of education includes fewer than three credit hours in understanding nutrition, and the focus on prenatal nutrition is only a small portion of the syllabus. The home birth midwife also follows the mother into the immediate postpartum and continues home visits to see how mother and baby function as a unit.

It is the midwife who is better versed in delivering babies in various but normal birth situations. A breech baby can be birthed safer in the hands of a midwife than a hospital attendant. She has not let her skills fall behind because medico-legal liability has dictated a breech birth to be enough of a risk as to deem a cesarean to be the required course of action; therefore, she continues to hone both her observational and palpating skills. In fact, Rebecca Watson of the New Mexico Department of Health has stated, “I sometimes wonder why [we bother compiling statistics on midwives], since their statistics are so much better than everyone else's.”

There are many variations on the only thesis available to opponents of home birth: What do the statistics say? Despite the enticement of a warm, peaceful and private birth that a home birth offers, the perceived importance of missing technology lingers like impending doom. In America, less than 1% of births takes place in homes. It is difficult for the other 99% of Americans to make the transition from technology as the benchmark for establishing worldwide leadership to the reality that the human body is designed to give birth and it has evolved to make many variations in labor and birth look so easy.

The Stockholm Birth Center Study followed one birth center’s outcomes over a ten-year period culminating in 2000 and comparing the outcomes to the associated hospital’s birth outcomes. The one strong observation in this study is the truism that many women will choose a birth center because of the perceived safety in having a hospital nearby. However, it is a mistake to conclude the birth center is free of institutional intervention. The study's results are negated because of the influence of the obstetrical backup. Every woman who chose the birth center for her birth location was still subjected to the institutional care package. This is the most influential determinant in whether or not a woman is "risked out" of laboring and ultimately delivering in the birth center.

A birth center so closely associated with a hospital is not autonomous and must operate under strict supervision by institutional birth practitioners. The authors themselves state they did not study the effect of individual labor and delivery protocols, but rather the care documented in each case as a "package." In addition, they have correctly remarked standards of maternity care do not exist, but they have again missed the mark on the importance of this statement. This is critical to interpreting the outcomes, because one solitary intervention can turn out to be the predictor of a birth outcome. For example, every care provider practices according to their comfort level; although every care provider will monitor a baby's heart tones in labor, *how* the monitoring is done varies by care provider. Continuous electronic fetal monitoring (EFM) can range in definition from ten minutes hooked up to a monitor every hour on the hour to a handheld doppler check through a contraction every few hours to a telemetry unit (a girdlelike band outfitted to wirelessly transmit fetal monitoring data) that allows the mother walk more freely.

The ability to walk freely even under continuous monitoring allows the mother greater mobility for finding a position that increases her ability to cope with her contractions. Setting aside the U.S. Preventative Service's Task Force's findings and stance that continuous fetal monitoring provides no benefit at all - and the data showing that continuous EFM results in more cesareans - it can be argued that fetal monitoring that limits a mother's mobility is therefore more likely to result in more intervention as the mother shows signs of distress and therefore the baby does as well.

The authors of the Stockholm Birth Center study argue that many other studies have reached conclusions similar to theirs. In the same publication we are offered a Cochrane Systematic Review of Home-Like versus Conventional Institutional Settings for Birth. Here the reviewers concluded births in home-like settings compared to purely hospital settings “provided only modest benefits including reduced medical interventions and increased maternal satisfaction.”

A hasty read of this data by institutional birth practitioners correctly supports their ingrained training that routine intervention is acceptable and “safe.” However, the paper actually clearly demonstrates that all births taking place in a hospital are going to meet up with interventions at some point during labor, and it is the overuse of technology that needs to be analyzed. Indeed that message is there somewhat cryptically as the authors instead hinder the possibility of improving on the scope of research by advising “caregivers and clients should be vigilant for signs of complications.” It is difficult for any woman who has given birth or who respects her body to hear such little value placed on the differences the studies do reveal, such as the “modest benefits” of “reduced medical interventions” and “increased maternal satisfaction.” Surely even one avoided episiotomy would be appreciated by the woman whose perineum would have been cut and would find several women healing from receiving an unnecessary episiotomy to be envious.

In 1998, a study of infant mortality in planned home births was conducted in Australia. Author Hilda Bastion reviewed these outcomes as neither hospital nor home births have defined what constitutes standard care. She reviewed both midwives and medical practitioners, registered and unregistered, minimal experience and heavy case load. Also included in the study were births that would be deemed risky by virtue of poor health in the mothers or other underlying health conditions. This is crucial to understanding the bias of many hospital birth proponents: It is not the intent of home birth advocates to claim home birth is best for everyone, but rather a viable option for low-risk and otherwise healthy women. The author goes so far as to note it is a disturbing trend that midwives may be encouraging and willing to take high-risk births because of the high number of low birth-weight infants counted in the statistics. In fact, it is quite possible that a woman who cannot afford good nutrition may also not be able to afford hospital birth care, and perhaps a midwife is her better choice than no care at all.

In general, birth care is divided into either purely institutional care or modified institutional care. No research exists on pure, spontaneous vaginal birth over an intact perineum without induction agents, drugs, surgery and instruments. What is available is mounds of research on what a mother or baby can "tolerate" in labor and what interventions have achieved an acceptable degree of risk. The acceptable degree of risk is not defined by an independent counsel but often influenced by the strongest or loudest lobbying effort, as witnessed by the American College of Obstetricians and Gynecologists' (ACOG) August 2007 statement on the advance of midwifery options for consumers. ACOG's bottom line is midwifery options must be controlled, and home birth as an option must be eliminated. The average consumer misses the bias and conflict of interest: A rise in home births means a decrease in income for a field already plagued by the reality that there is no money to be made in natural childbirth.

In addition to a lack of studies of organic birth as defined above, there are no long-term, randomized longitudinal studies to confirm or deny the correlation of many interventions. For example, the impact of a mother's drug use in labor on emotional bonding, breast-feeding, postpartum depression, later drug abuse (baby as a young adult), etc. In the 1970s, Doris Haire, the President of the American Foundation for Maternal and Child Health, said, "No drug has been proven safe and effective for use during pregnancy or childbirth." Considering that 25% of drugs introduced in the market today are recalled or pulled off the market in 1 to 5 years, this statement has never been more true. Until such time that midwifery care can be studied with a critical but appreciative eye, we will find only the weakest of studies boxed in by outdated beliefs that American women cannot afford to birth outside of a medical institution.

There is sufficient evidence to substantiate a need for inquiry into myriad routine medically managed birth care protocols by our governmental health care watchdog agencies. Included in this inquiry should be parallel proactive support to educate the public on the feasibility of home birth as an option for healthy, low-risk women expecting a normal birth. An independent group monitoring the reporting of home birth outcomes should be a part of the government health budget and push the U.S. to participate in the global Millennium Development Goal 5: to improve maternal health. Humans - not machines, numbers and black and white text - should be the dominating active birth participants in America. If we cannot put forth the worthwhile effort to show ourselves as an advanced peaceful society we will face the greatest risk to our survival. The incidence of finding a skilled birth ***care*** provider in America: low.

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