NATURALIZED BIRTH

CHILDBIRTH WITHOUT FEAR

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Over the past few centuries childbirth has become increasingly influenced by medical technology. Today medical intervention is the norm in most western countries. Interrupting the natural process of birth with unneeded interventions, such as drugs and surgical procedures, has become a widespread problem. Although the use of "high tech" medicalized maternity has saved lives, its unnecessary and unwarranted use has proven to backfire. Childbirth without fear is a reality that needs to be understood by women, midwives and obstetricians. What is known about women's wishes and fears should be addressed, so that a woman-centered, clinically effective service can be developed. I am arguing that perhaps normal birth has become too "medicalized" and that higher rates of normal uninterrupted births are in fact associated with positive beliefs about birth.

Implementation of evidence-based practices within the hospital along with communication between the providers and clients are the other crucial factors for naturalization of the birth process. Birthing families as well as health-care providers should be able to make decisions derived from unbiased evidence. This will aid in the promotion of natural birthing experiences. Whether in a hospital setting or at home, we need to *trust* birth in order to *give* birth naturally.

Many families are not aware that in most cases the birth process does not need intervention. Naturalized birth means putting the woman back in control of her outcome and allowing her to make the proper, educated decisions about what will or will not occur during her birth. The midwife, obstetrician or anyone other than the family should not influence this decision. Their role should be to merely "catch" the baby, unless complications arise warranting their skills and interventions.

I recently interviewed Debra Barbic, a mother of six who delivered her first child in a hospital via cesarean section due to a breech (legs first) presentation. Her next child was delivered vaginally at a birthing center, and the last four were delivered at home by either her husband or a midwife. All but one of her home births was in breech, but she chose to birth at home.

I had to ask: why would she choose to birth at home even though she was at risk for complications?

The answer I received was simple; she did not feel she had a choice. She said that her experience in the hospital with her first child was an "absolute nightmare." Her doctor refused to try and turn the baby, admitted her into the hospital to lie flat on her back for two weeks for no apparent reason, then proceeded to take the baby out via cesarean section, at his convenience, which was still five weeks early. Not to mention, the staff did not allow her to see or touch her new child for four hours.

She complained that the staff was not attentive to her or her husband's wishes, saying they gave formula to their newborn against their demands to ensure proper breast-feeding. In addition, the nurses would not let the newborn sleep with its mother or stay in the room with her. She also claimed they served her non-nutritious meals which were often full of sugars, fried goods and fat.

Debra explained her view of the real reason why this type of disaster takes place in our hospitals: "Insurance companies put pressure on the physicians to take every caution possible to decrease the liability of the establishment. What they do not realize is that these 'cautions' can be detrimental to the women giving birth."

Labor and birth are functions of the autonomic nervous system and are therefore out of conscious control. As a result, there are two approaches to assisting birth:

~Medicalized birth: Override biology and impose external control using interventions such as drugs and surgical procedures.

~Naturalized birth: Work with the woman to facilitate her own autonomic responses.

Naturalized birth also means that the service to the mother and baby are based on worthy evidence-based use of technology and drugs. Birth needs to be given back to the woman and her family. Women need to have the right to have any errors committed during their birthing to be their own and not someone else's. The widespread inability to know what normal, naturalized birth is has been summarized by the World Health Organization:

"By medicalizing birth, *i.e.*, separating a woman from her own environment and surrounding her with strange people using strange machines to do strange things to her in an effort to assist her, the woman's state of mind and body is so altered that her way of carrying through this intimate act must also be altered and the state of the baby must equally be altered. The result is that it is no longer possible to know what births would have been like before these manipulations.

"Most health care providers no longer know what 'non-medicalized' birth is. The entire modern obstetric and neonatological literature is essentially based on observations of 'medicalized' birth."

Over the years we have seen a struggle between these two approaches to maternity care.Today it seems there are three kinds of maternity care:

~The highly medicalized "high tech" doctor-midwife hospital centered care found, for example, in the USA, Ireland, Russia, Czech Republic, France, Belgium and urban Brazil.

~The naturalized approach with strong, more autonomous midwives and much lower intervention rates found, for example, in the Netherlands, New Zealand and the Scandinavian countries.

~A mixture of both approaches found, for example, in Britain, Canada, Germany, Japan and Australia.

Seventeen years ago in Brazil, the World Health Organization Conference recommended birth be controlled, not just by individual doctors and hospitals but also by evidence-based care monitored by the government. Birth, which had been taken from the community and slowly but surely changed into hospital-based care during the last hundred years, was to be given back to the community.

This same conference considered the next step, giving birth back to the woman and her family.

Today, prevailing Western medical opinion is that 'modern' obstetric-maternity care saves lives and that attempts to bring maternity care extremes under control are retrogressive. Many with this view believe the only reason out-of-hospital midwife-attended birth still exists in developing countries is because modern medical practice is not available.

We override biology at a risk. For example, if we stop using our bodies they go wrong. It is "modern" to get around in a car resulting in little walking. Then science finds out that our bodies need such exercise or we get cardiovascular problems. The post-modern idea is to go back to walking, running or cycling. This is seen as progressive, not retrogressive. Along the same lines, naturalizing maternity care is not retrogressive but post-modern and progressive.

Every change in the human condition, such as social and technological development, has potential for both positive and negative effects. It seems that the positive effects of such development overpower the negative effects until a level is reached where social and economic benefits reach everyone, and then hidden negative effects begin to come forward.

In the same way birth interventions, such as cesarean sections, sometimes save lives and sometimes kill. Maternal mortality even for elective (non-emergency) cesarean sections is approximately three times higher than for vaginal birth. For about 50 years the maternal mortality ratio in the United States came down. Then in the 1980s the maternity mortality ratio began to rise and, according to the U.S. Centers for Disease Control & Prevention, it rose from 7% to 10% in 1990. While this ratio continued to decline in other industrialized countries, in the U.S. the maternal death rate continued a slow but steady rise through the 1990s and, according to the World Health Organization is now higher than at least 20 other highly industrialized countries.

This suggests that we are now at the point in maternity care where the positive effects of development and technology are approaching the maximum and the negative effects are surfacing. This helps to explain why advances in technology and in development cannot lead to improvements in health unless the technology is in balance with natural processes and is accompanied by naturalized health care.

Here is an example: If an elective cesarean section is done after labor begins, it may, in some cases, facilitate natural processes. But waiting until labor starts means doctors lose the possibility of scheduling the procedure at their convenience. If, as is almost always the case, the doctor tries to get around the natural process by performing cesarean section before the start of labor, there is a greater risk of respiratory distress syndrome and pre-maturity, both killers of newborns.

Many health care providers and the organizations they represent continue to believe in the dangers of planned out-of-hospital birth, either in a birth center or at home. They reject the overwhelming evidence that planned out-of-hospital births for low risk women are safe. The response of providers to this evidence is, "But what if there is an out-of-hospital birth and something happens?" Since most providers have not attended an out-of-hospital birth, their "what if?" question contains several false assumptions.

The first assumption is that in birth things happen fast. Actually, with very few exceptions, things happen slowly during labor and birth. A true emergency, according to Sonja Gregg, a direct entry midwife, is extremely rare and often the midwife in the birth center or home can take care of the emergency.

The second assumption is that when an emergency develops there is nothing an out-of-hospital midwife can do. Someone who has never observed midwives at out-of-hospital births can only make this assumption. A trained midwife can anticipate trouble and usually prevent it from happening in the first place as she is providing constant one-on-one care to the birthing woman, unlike the hospital where nurses or midwives can only look in occasionally on several women in labor for which they are responsible. Then when their shift ends a new physician or nurse is there to take over.

With few exceptions, if trouble does develop, the out-of-hospital midwife can do everything that can be done in the hospital including giving oxygen, Pitocin (synthetic form of oxytocin, which helps the uterus contract) and intravenous fluids. For example, when a baby's head comes out but the shoulders get stuck, there is nothing that can be done in the hospital except certain maneuvers of the woman and baby, all of which can be done just as well by an out-of-hospital midwife. The most recent successful maneuver for this event reported in medical literature is named after the homebirth midwife who first described it, the "Gaskin Maneuver" (J.Bruner, *Journal of Reproductive Medicine 43*, 1998).

The third assumption is there can be faster action in the hospital. The truth is that in most hospitals the woman's doctor or midwife is not even in the hospital most of the time during her labor and must be called in by the nurse when trouble develops. The time it takes for a doctor or midwife to get to the hospital is as much time as the transport of a woman having birth at a birth center or at home. Even in hospital births, when a cesarean section is warranted, it takes an average of 30 minutes for the hospital to set up for surgery and to locate the anesthesiologist or surgeon.

In one study of 117 hospital births with emergency cesarean sections for fetal distress, 52% of the cases had a decision-incision time of over 30 minutes. So during those 30 minutes either the doctor or the out-of-hospital birthing woman are in transit to the hospital. This is why it is crucial for a good collaborative relationship between the out-of-hospital midwife and the hospital, so when the midwife calls the hospital to inform staff of the transport, the hospital will not waste time in making arrangements for the incoming birth woman. These are the reasons there are no data to support a single case of the "what if" scenario used by some doctors to scare the public about out-of-hospital birth.

Some members of society tend to put blind faith in technology and the thought *technology=progress=modern.* On the flip side is the lack of faith in nature. So it seems the idea is to conquer nature. This results in many attempts to improve on nature using scientific evaluation, yet science all too often shows nature right instead. Doctors replaced midwives for low risk birth but science proved midwives safer. Hospital replaced home for low risk birth and then science proved home as safe with far less unnecessary intervention. Hospital staff replaced the family as birth support. Science then proved birth is safer if the family is present. Lithotomy (lying down) replaced vertical birth positions, and science proved vertical positions safer. Newborn examinations away from mothers in the first 20 minutes replaced leaving mothers with babies, then science proved the necessity for maternal-infant bonding during this time. Formula replaced mother's milk, then science proved breast milk most beneficial. The central nursery replaced the mother, then science proved rooming-in most beneficial.

The typical example of medicalization and unnaturalization of birth is unnecessary cesarean section (CS in medical idiom) where the surgeon is in charge and the woman no longer has any control whatever.Cesarean sections save lives but there is no evidence that the rising CS rates over the years have improved birth outcomes. As indications for CS expand and rates go up, fewer and fewer lives are saved. According to Sue Trezona, a certified nurse midwife (CNM), "It's only logical that eventually a rate is reached at which cesarean sections kill almost as many babies as they save." This statement is validated by the fact that the risks of this major surgical procedure do not seem to decrease with its increasing use.

Women and their babies are currently paying a big price for the promotion of CS by some doctors. The scientific data on maternal mortality associated with CS suggest the rising maternal mortality rates in the U.S. and Brazil may be, at least in part, the result of their high CS rates. Both these countries need to carefully look at all maternal deaths to test the strong belief that rising rates of maternal death are associated with high rates of cesarean section.

The data on other potential risks for both woman and baby associated with CS mean both are paying a big price in current birth as well as in future pregnancies.