ARTIFICIAL CHOICE

BIRTH PRACTICES THAT KILL

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The United States Centers for Disease Control & Prevention report that seven out of every thousand American babies died in 2002, totaling 27,970 infant deaths. "Every day, on average, 77 babies die in the United States and one woman dies in childbirth," writes Nicholas Kristof, a journalist for *The New York Times*. Many Americans are appalled by these statistics. "According to the CIA World Factbook, Cuba is one of 41 countries that have better infant morality rates than the U.S.," Kristof writes. Kristof's chief aim is to connect the rising infant mortality rates to a failing health care system, and he believes these fatalities are afflicting those "intertwined with poverty." Kristof is right. Our country *is* struggling with uninsured or underinsured patients not receiving proper medical care. The infant mortality rate in this country is, indeed, a horror story. However, it's not just the poor who are suffering. Our advanced health care system's mismanagement and overuse of medical technology has produced a high rate of cesarian births. This abrupt rise in America cesarians is the cause of the rising infant mortality rate. Contrary to Kristof's argument, forced cesarians, daylight obstetrics, fear of malpractice suits, elective cesarians and greed on the part of physicians and hospitals are what's killing close to 30,000 babies a year. Most cesarian sections are performed on wealthy women and in private hospitals; the least likely to get a cesarian section is a woman on Medicaid.

The number of women having cesarians is up both nationally and locally. Two decades ago the World Health Organization (WHO) declared cesarian rates in any area should not exceed 10%-15%. WHO warns obstetricians that cesarian rates are continuing to rise in this country and that the numbers are astronomical. "Fifty years ago, fewer than one American baby in 50 was delivered surgically," says Fredric D. Frigoletto in the April 25, 2005 issue of *Newsweek*. During the 1970s only about 5% of all babies were born surgically. Today in the United States, over *one-quarter* of all babies are delivered surgically.

New statistics in Oregon are even more appalling. Columbia Memorial Hospital in Astoria boasts a cesarian rate higher than the national average at 33%. Giving birth at Tillamook County General Hospital, you may be one of *44%* who have c-sections! Immanual Hospital in Portland, a high-risk birthing center that caters to special situations including babies with anomalies, diabetic and HIV infected mothers and various other dangerous situations, only has a cesarian rate of 37%. 'Joyce' of Oregon Human Services Health Statistics Department makes this statement when comparing the Oregon hospitals: "One would expect much lower rates at the small, low-risk hospitals like Columbia and Tillamook; and yet there is little difference." Justifying the high occurrence of cesarians is difficult; such a drastic rise can only be explained in one way: many women are having their babies surgically for little or no medical reason.

"Extremely small" babies, weighing less than a pound at birth, are the *key* cause of infant mortality. The greatest numbers of these tiny babies are being born within the low-risk group of healthy, young mothers "...from 20-34 years old...across most racial and ethnic groups...and were singleton births," according to the Center for Disease Control report of February 2005, which lists "recent changes in the medical management of pregnancy as a factor in extremely small babies. And...in 2002, 57% of very low birth weight infants were delivered by cesarian." These facts dispel the notion that infant mortality plagues only the impoverished, or that higher maternal ages and multiple births are the leading causes. Labors induced for breeches and twins typically occur two to three weeks before due dates to avoid the obstetricians' "nightmare." Inducing early is a travesty, especially with first-time mothers who frequently deliver late. A few weeks early, added to a miscalculated due-date, equals a "preemie" with underdeveloped lungs, the greatest risk factor associated with death. Multiples pose an even more lethal threat than a premature singleton because the weight is split. Risks associated with being born too soon are clear.Muddier is the question of whether or not a cesarian is needed.

Growing regulations mean more required cesarians. Strong women hauling breeches, twins, and obliques are instructed in their ninth month that they must have a c-section. Hospital regulations require the surgery in these cases, and, the sooner the better because contractions mustn't begin before the procedure. This is a problematic approach, because it is not uncommon for breeches or obliques to "flip" into the vertex position during labor. Obstetricians, no longer trained to deliver odd-presenting babies vaginally, are loath to let the pregnancy continue for fear an "emergency" will ensue. Twins are almost always delivered by cesarian too, although this is not medically necessary. Many of our grandmothers and mothers pushed them out, but increasingly women think they'll perish delivering twins vaginally. Policy is hard to follow in regards to multiples because delivery depends on position of babies. If both babies are presenting vertex, then they are allowed vaginal passage; if both are breech, they are delivered surgically. If the first twin is vertex, it can be delivered vaginally, but the other must be c-sectioned. "If a mother with twins opts for a vaginal delivery she is what we call a 'double set-up.' She is put in a surgical suite so that a c-section can be performed," says 'Barbara', labor and delivery nurse. My personal birthing story illustrates this overly conservative approach to abnormal presentations.

Pregnant with baby number four, my baby was persistantly in a transverse lie. I intended to have a beautiful home birth as I had with all of my other children. My lay midwife and primary care physician were a bit concerned when three weeks before my due-date my baby boy was still transverse. My midwife attempted an external version (a procedure in which the baby is somersaulted in the womb from outside). My baby flipped breech, a deliverable position for homebirth, but without delay, he returned to his favorite spot refusing to budge. Another week passed, and my physician urged me to get a version from someone in the medical field who could give me a shot of *terbutaline* to relax my uterus. Calling every doctor and hospital around, it became clear the majority refused to conduct the version and rather requested I birth surgically.

Lucky for me, a retired obstetrician from Asia assured me he had witnessed my situation many times in his practice and not to worry, all the while assuring me the baby would turn over during labor. Taking comfort, but continuing to agonize, my physician set up an appointment for me to have a version at Oregon Health Sciences University Hospital. *Terbutaline* was injected and an external cephalic version done. Abraham was one of the 7% that won't stay, and a reluctant team wouldn't try It again. Without warning, the staff suggested a cesarian section right then! Refusing their offer, we got ready to go home. Understandably, this presentation is the most dangerous because a prolapsed cord can easily occur, and an attempt at vaginal delivery will likely kill the baby. OHSU obstetricians and students wanted very much for me to understand these dangers. A resident asked, "What do you intend to do with a prolapsed cord?"

"I'll put my butt in the air and get myself to the hospital for a cesarian," I answered. Arguing reached a stalemate and I got up to leave, with one woman shouting from behind me, "You'll *kill* your baby!" Needless to say, during labor Abraham flipped into the vertex position just like the wise old obstetrician had predicted. My vaginal birth resulted in a 10 pound baby boy. Had I not birthed three other children, been an older and more ornery mother, or not researched what was going on in relation to my pregnancy, I would have been another cesarian statistic. The medical community wanted to intervene before allowing my body to fulfill its role, as it successfully did.

Women may be adamantly against a cesarian, yet are not allowed a vaginal birth because they have had a previous c-section. Fewer hospitals and physicians are permitting vaginal births after c-sections (VBACs). Many Oregon hospitals are now banning all VBACs, including Columbia Memorial Hospital in Astoria. Most women are told that the risk of uterine rupture is too great to allow the powerful contractions of labor. This medical movement is a joke because the odds of uterine rupture are estimated between .5% and 1%! As long as the woman's labor is not induced there is only a 1% chance of her uterus rupturing. "Once a trend like this starts it gains momentum when the process has liability and logistic ramifications," John C. Hobbins wrote in "Cesarians For ALL?" (OB/GYN Clinical Alert, October 2004). Banning VBACs is part of the medical community's scheme to avoid malpractice suits.

Induction of labor is another birthing technology that leads to cesarians. Routinely used in our country, and very popular, for both doctors' and patients' convenience, inductions are the most apt technological disruption to result in a cesarian. "...research has shown an association between fetal distress and the use of synthetic oxytocin," Sally Inch wrote in *Birth Rights: What Every Parent Should Know About Childbirth in*