

"Maternal Health and Childbirth"

National

RESOURCE GUIDE **4**



NATIONAL WOMEN'S HEALTH NETWORK

The Women's Center

A Note to Our Readers



We, as women, by choice and necessity are becoming more active participants in the protection and promotion of our own health. Increasingly, we are finding that the health services we need are unavailable, inadequate, and sometimes dangerous. This year alone, hundreds of thousands of women will have unwarranted hysterectomies, mastectomies, and sterilizations. Others will be exposed to insensitive childbirth practices, while yet others will be prescribed drugs that have been linked with cancer. There are presently 14 million American women who take oral contraceptives or use intrauterine devices. The long-term effects of these drugs and devices are unknown.

To deal with many of these concerns, women need a centralized, accessible source of personal health information. As a first step, the Women's Health Clearinghouse, a project of the National Women's Health Network, compiled nine health resource guides on selected women's health issues: abortion, breast cancer, birth control, DES, hysterectomy, maternal health and childbirth, menopause, self-help, and sterilization.

This guide, along with the eight other health resource guides, has been developed from a wide selection of popular, feminist, and medical sources and has been designed to be used in a variety of ways. The directories of local women's health centers, national organizations, and resource people can be used to help organize political action and build coalitions with other health activists. The discussions of the major issues, together with the comprehensive bibliographies, can serve to increase your own personal health awareness, while the listings of libraries and information centers can facilitate your further research.

Although the material in this guide has been reviewed for technical and factual accuracy, it may not be as sensitive to your needs as we would like. Bear in mind that there is no longer any area of health care, especially concerning women, which is not without controversy. Medical experts frequently disagree. Consequently, you may find differing opinions on any one issue. In addition, health and medical information is changing so rapidly that what you read here may already have been superseded by some new development.

By sharing this information, the National Women's Health Network does not intend to give medical advice, but rather to provide information which will enable you to be an active health care decision maker.

We hope this guide will be useful to you and we welcome your comments.

National Women's Health Network

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The Women's Center

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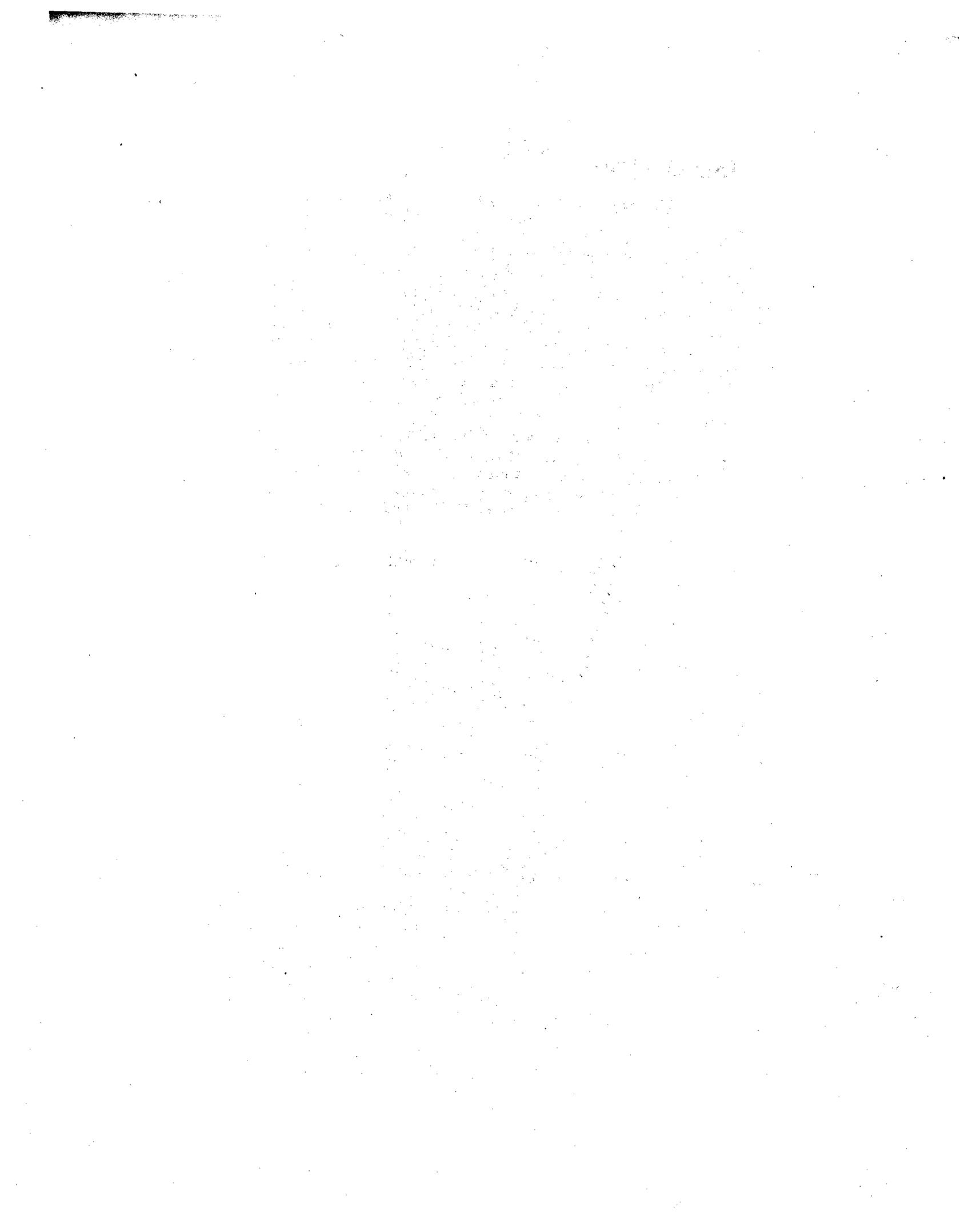
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Introduction

Childbirth and maternal health touch many movements and a wide range of issues which are difficult to compress. For their help with this effort, we would like to thank Network members Gena Corea, Ann Sablosky, Zoila Acevedo, and Anne Seiden, and Network Board members Joan Mulligan, Francie Hornstein, Doris Haire, Judy Norsigian, and Byllye Avery. We would also like to thank the many readers who gave us critical feedback on these selections, especially Jessica Lipnack.

In addition, we appreciate the generosity of Judith Luce for permission to print her personal memoir of Demara's birth. Thanks also to the many publishers and authors who cooperated with us in giving permission to use the work printed here.

Childbirth, as the expression of a woman's fertility and reproduction, needs always to be considered alongside the related issues of women's fertility control. This context is presented through Network Guides #8, Abortion; #5, Birth Control; #7, Self-Help; and #9, Sterilization.

Why do teen-agers Midwives: 1 ers?

Midwives:
Acceptance
Is Growing
Nationwide



Panel: use fetal monitoring
for high-risk patients only

Fetal Monitoring's Effectiveness Is Questioned

Modern Midwives Struggle to Survive in Arkansas
Offer To
Midwifery!
Birth
A Childbirth Alternative

Why You Victory for ould uld Be Born?

Some birth
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feeling alone, needing to talk
ative
Birth

'One Mother Dies for 8 Newborns
Saved With Electronic Monitoring'



Unwed Births: Why They Are Up 100 Percent

Procreation Politics

SWENSON Childbirth and maternal health have not been overtly political issues in our society since the early '30s, when the Sheppard-Towner Act of 1920 was repealed. Thus the United States has no comprehensive preventive care program for all mothers and children, unlike virtually every other Western industrial nation. Recent efforts to create legislation which would provide complete coverage for this group separately have also failed. Such services as are provided publicly exist only for the poor or special populations when provided by government; otherwise, they exist only as the voluntary initiative of the medical profession makes them available. There are still states, such as Alabama, where even the poorest women must pay for their own maternity care or do without. In many rural areas all over the United States, including the depressed Northeast, such physician-run clinics as were once serving poor women are closing. The effects on outcome are clear (See "Maternal Health" article in this Guide).

The power of organized medicine, organized obstetrics in particular, to defeat most measures not to its liking has been demonstrated steadily throughout this century. This power promises to grow even stronger in the future, as groups such as the American College of Obstetricians and Gynecologists (ACOG) establish their entire headquarters in Washington, D.C. so as to better influence legislation and regulation.

But professionals and experts have already been making the key decisions in maternal health and childbirth since before the turn of the century, partly because birth was the first normal function of women to become medicalized and brought under entirely male control. Most governments today consider professional medical expertise in this area indispensable, if not infallible, and depend heavily on it. Thus there is a virtual fusion of medical opinion with public policy. While logically this should be seen as a conflict of interest on the part of one relatively small and narrow group, which stands to gain financially from its own judgments and decisions, in fact the issue of conflict is never raised, which seems a measure of government's dependency on their opinions. Government appears to acknowledge that allopathic medicine has achieved what amounts to a monopoly over childbearing management in the United States, since in almost all states delivering a child is defined as the practice of medicine (or osteopathy or, in selected situations with medical collaboration, midwifery). Over the past twenty-five years, while maternal and child health interests have waned, population and population control interests have risen. This field now claims Under-Secretary status in the federal structure. The problems have been re-defined entirely. Physicians are now generally recognized as the spokesmen for women's and children's health and for population management at every level of the system.

SWENSON

Despite the nearly total domination of medicine over these policies, a range of groups with different concerns at times present challenges to the existing system on one or another issue within the general framework of maternal health and childbirth. Occasionally, they are successful, as when legislation was passed guaranteeing maternity leave as disability. But thus far there is no coordinated, overall effort or coalition which might be capable of creating sustained, effective opposition or of developing a powerful program or constituency of its own. For the moment, single issue struggles appear to be more rewarding.

Feminists have generally been more concerned with the struggle for the right of women to control their fertility through contraception and abortion precisely because these are the rights so fundamental to a woman's ability to control her own body, her life, and her participation in society. The struggle over this right continues, as new threats continue to be mounted from the right. As fewer women become mothers, however, and as fewer still become mothers more than once or twice, the group of childbearing women shrinks to the smallest size in this country's history. The power of women and families to bring about changes in the system of maternal and child health services on which they are obliged to depend when they do choose to have babies thus becomes even more limited. Unless coalitions and linkages with other groups are made, no one group could become strong enough by itself. Furthermore, there is no tradition of this type of participation. While at least some mechanisms--however token--for citizen and consumer involvement in most areas of health policy-making and planning have been or are being developed, in the area of maternal health or maternal and child health, and especially maternity care, they never have been.* This is true in Britain as well as in the United States and in most other Western industrialized countries, though some, notably the Netherlands, have been much more responsive to their women's wishes than the others. It is vital that this precedent be established before any national health program is instituted.

The movement to change hospital childbirth practices and bottlefeeding has been growing and diversifying since the early 1950s, the point at which virtually 100 percent hospitalization was achieved. But the hospital as the proper place of birth and the physician as the rightful attendant was not questioned by most parts of this movement until the mid-1970s. Primarily parents, with some professionals, the movement has been characterized rightly as pro-natalist, though including those who accept fertility control in some if not all its forms. While often present in the past, open anti-abortion, anti-ERA, and other right-wing sentiment has recently become a significant force in the movement toward alternatives to conventional births in hospitals. The diverse elements of the movement have

*For example, almost all of the U.S. Public Health Service programs have citizen/client advisory groups attached to them. There is no analagous role for clients and non-professionals in maternal and child health programs.

SWENSON

thus far focused on the practices of individual physicians, midwives, or institutions, in the interests of the improved experiences of individual women, couples, and families through education and preparation. Little or no attempt has been made to mobilize the hundreds of thousands of members of the different groups for political action or policy initiatives around these issues. However, there are signs that this may happen in the future, since most of the major groups have now presented position papers on planning, some of them together.

But the issues in maternal health are not only about the quality of childbirth. Adolescent pregnancy has become a major issue in our time for many reasons, chief among which are the extremely high and rising rates among teens 15 and under, who also have the poorest outcomes, physically as well as psychologically. There are around one million teen pregnancies every year, two-thirds of which are carried to term. Although the issue is currently receiving a great deal of government attention and funding, the emphasis is not on preventive educational, contraceptive, or abortion services, but rather on support of the continued pregnancies and ensuing parenthood. Failure to prevent is far more costly in every respect, but the current political climate makes prevention unpopular.

Pre-natal diagnosis and genetic counseling are receiving increasing attention. For example, policy bodies such as the Hastings Center recently recommended that amniocentesis be made much more widely available, yet said nothing about the fact that ultrasound, a concomitant technology in proper amniocentesis, has shown damaging effects on animals and has not been proven safe for the developing fetus; nor did the report mention that British studies have shown an increase in spontaneous abortions following amniocentesis. Furthermore, important ethical issues such as sex pre-selection are raised by these procedures. They are being resolved, if at all, with little or no input from women, who both bear the children and care for them afterwards.

Occupational health is a new and rapidly growing movement, particularly in relation to women's health, both reproductive and non-reproductive. The risks to women, and men, in lethal environments are only beginning to be studied, but thus far the focus has been predominantly on women, some of whom have felt obliged to be sterilized rather than give up their jobs or run the risk of giving birth to deformed children. Legislation, research, and action groups are all important and increasing.

Environmental hazards, particularly defoliants, have been shown to cause birth defects, not only in Vietnam, for which they were developed and where they were extensively used, but recently in the Northwest United States, in Arkansas, and in northern New England as well. Also, as pesticides become banned in the U.S., they are exported to other countries where they are put into wide use. This increases the health and reproductive risks to those working there; ultimately these substances are used on crops which return to the United States for consumption here. Pressure on the FDA and multi-national corporations is just beginning.

**I'm
fifteen
years
old
and eight
months
pregnant**



"For many child-mothers . . . the worries of money, child care, school, work, housing, adequate food, medical care, and finding the available social services (if they exist) are too much. One girl couldn't cope any longer and just dropped her baby down a two-flight stair well. Some mothers just give up and commit suicide."

**Leslie Aldridge Westoff
New York Times Magazine
February 22, 1976**

Population Institute/cpf

SWENSON

Nuclear power overshadows all the other environmental hazards in its potential long-term, permanent damage to women in the reproductive age groups, to their children, and ultimately to everyone.

Some drugs and procedures used in pregnancy are so new and experimental that no evaluation of their safety has yet been done: stress tests, oxytocin challenge tests, for example. Yet they are put into increasing use. Others have known risks, such as X-ray or DES (diethylstilbestrol), yet they are still used, often inappropriately. (See Guide #6: DES.) The Pill, the IUD, and Depo-Provera can cause maternal damage, birth defects, and sometimes still birth if given in early pregnancy, yet few women are told of the risks when they choose or receive these birth control methods. Meanwhile, research and policy continue to encourage more invasive, systemic methods, largely because of population control imperatives. (See Guide #5: Birth Control.)

All of the sexually transmitted diseases carry risks to women's health if undiagnosed and untreated; these vary in severity and variously affect either mother or baby or both. Some cause infertility, some miscarriage, some severe complications in childbirth. Federal policy is very weak in this area, particularly concerning prevention and education.*

Insurance coverage for maternity care and a more equitable method for spreading the enormous costs of the high-risk care of a minority are issues which have only recently been raised and have not all been seriously addressed or resolved. Most proposals simply urge third-party coverage and do not build in methods for reducing costs or developing prevention programs. Closely related is the question of midwifery care and the direct reimbursement of midwives by third-party payors. Midwives are being denied both privileges and payment in many states. Much state-by-state and national legislative work needs to be done on this question, as well as on the related question of greater federal funding of midwifery training, including training grants to students and development grants for faculty.

Planning for maternal and child health services and for childbirth and maternity services suffers seriously from the lack of input by concerned and informed consumers. (See "Maternal Health" section in this Guide.)

In the area of direct services in childbirth, the controversy is already quite heated at the national level, with Senate hearings, National Institutes of Health Consensus Development hearings, and Food and Drug Administration committee hearings on a wide variety of issues: the routine induction of labor, the tripling in the cesarean section rate, the routine use of ultrasound and fetal monitoring, the short- and long-term effect of obstetrical medications and anesthetics on the infant and on the neurological and psychological development of the child. While few of these issues have been resolved, most preliminary reports suggest that all of these procedures, when used on the present routine basis, are at best unnecessary and at worst harmful. (See Bibliography.)

*Write to STD, Boston Women's Health Book Collective, for a new sample brochure on sexually-transmitted diseases.

Studies on midwifery practice, on the other hand, whether current or in the past, whether at home, in the hospital, or in birth centers, consistently show superior outcomes: fewer forceps or cesarean sections or episiotomies, fewer stillbirth or low-birth weight babies, lower infant mortality rates. It is becoming clearer that one cure for the epidemics described above is more midwives. This requires activism at every level.

As the out-of-hospital birth movement continues to grow, hospital birth practices have come under closer scrutiny, with the result that it is no longer possible to say that the hospital is the safest place for every birth. Many parents now want to avoid the hospital as much for reasons of safety as for reasons of psychological security. Increasingly, as each woman has only one or two babies, childbearing women are divided into two groups: those who will accept any intervention in the belief of safety and in the hope of a perfect baby, and those who will accept some risk, including the slight risk of death, in the hope of a safer and more meaningful, unrepeatable experience for everyone involved. Most professionals agree with parents in the first group, but the number of professionals in the second group is growing.

The idea that parents should have the freedom to make this choice themselves is unacceptable to most of the leaders of organized obstetrics, whose harassment techniques have included labeling home birth as "child abuse" and "maternal trauma" in the national media and circulating distorted statistics from state health departments on emergency births out of hospital. One result is that at least three women in different parts of the U.S. have been taken forcibly from their homes while in labor by police and made to deliver in hospitals. Another result is that some hospital staffs have refused or revoked admitting privileges to physicians involved either in attending home births themselves or in providing back-up support to midwives so engaged. Several midwives in different parts of the U.S. have been arrested and charged variously with: murder, practicing medicine without a license, or practicing midwifery without a license. Others have been fired for simply giving pre-natal care to home birth couples.

Thus far no midwives have been convicted, but the harassment continues against lay midwives, family practice and other physicians, against home birth education groups, against schools of midwifery, against midwifery and nurse-midwifery group practices, and against out-of-hospital birth centers. In Massachusetts and in Pennsylvania currently, nurse-midwives in hospitals are not permitted to deliver babies unless an attending physician is present in the room--an insult to the midwives' training and a ridiculous waste of both personnel. In neither state are midwives reimbursed.

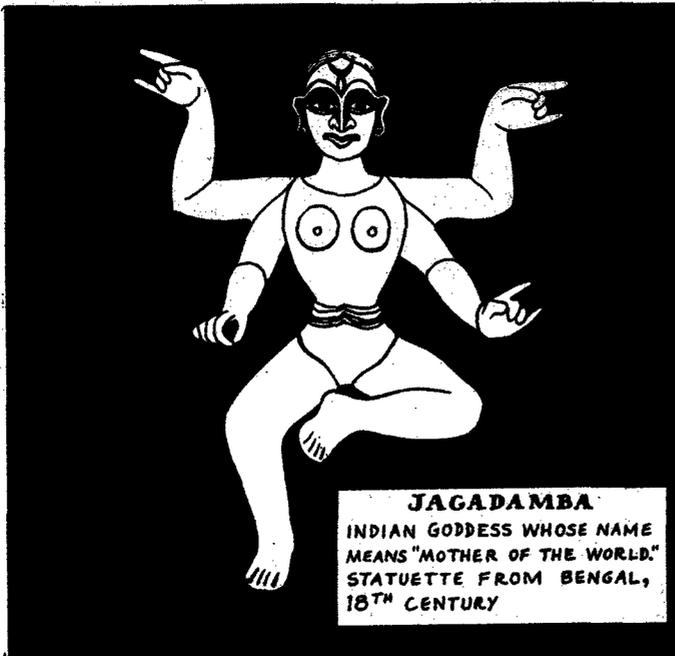
Breastfeeding is on the increase, though good information is still hard to find. Recently, the American Academy of Pediatrics announced at last that breastfeeding is best, that there really is no adequate substitute for it. But even as they say this, formula companies continue to distribute free samples in third world countries, despite the risks of death to babies

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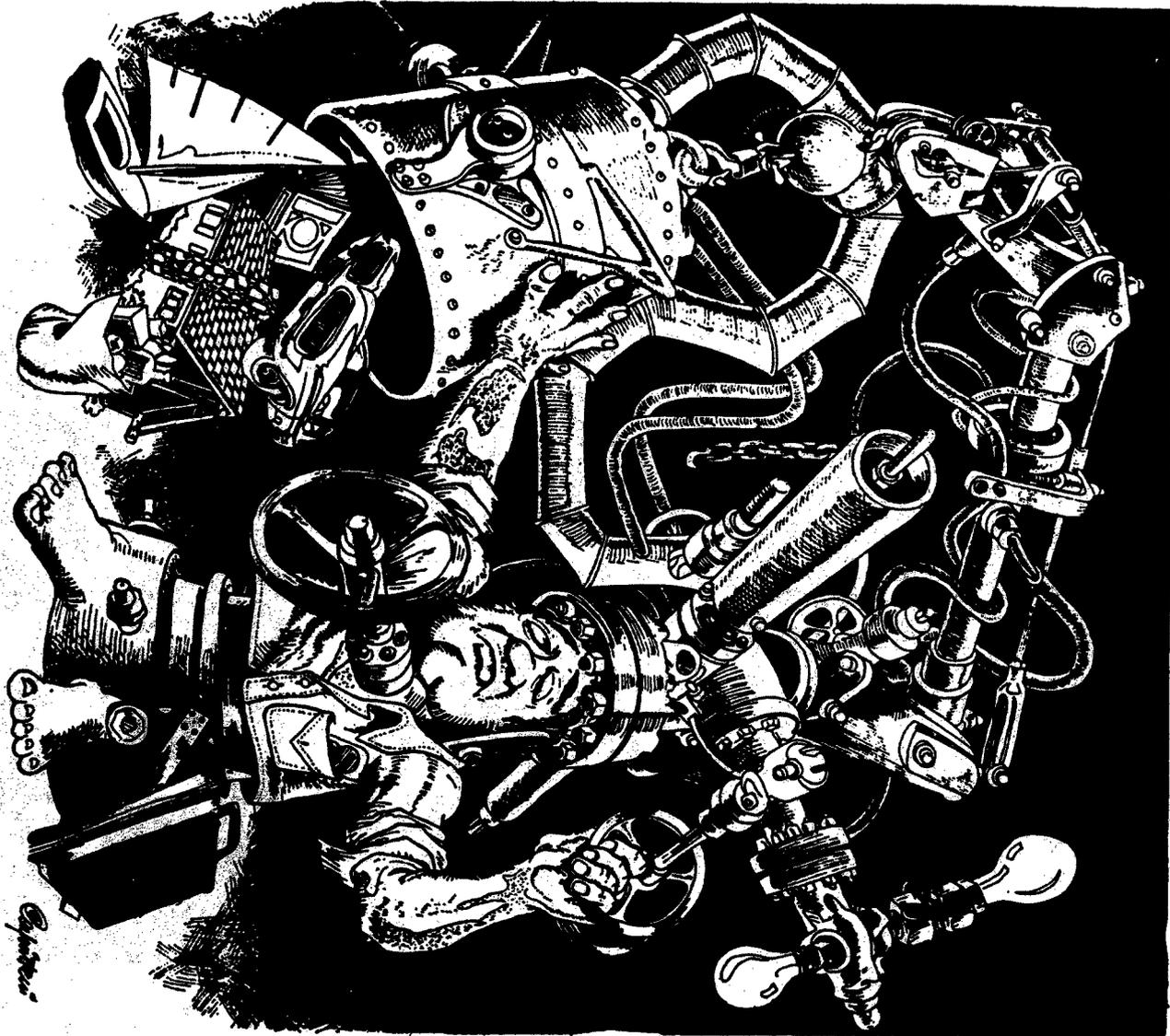
there. And in this country, practically all mothers giving birth in hospitals are given free samples to take home.

A woman having a baby today has many difficult choices to make and none of the certainty that she might have felt even five years ago in making her decisions. A woman trying to protect herself from dangers to herself, her unborn baby, or her yet-to-be-conceived baby, has an increasingly long list of potential problems to be wary of. And in her efforts to avoid dangers and problems, she often seeks help from professionals who cannot help but instigate further interventions as safeguards. Community-based preparation classes compete only with difficulty in trying to prevent disasters through information.

Fortunately, alternatives of many different kinds are being created all over the United States in response to the need. Birth centers, midwifery practices, home birth services, and a wide variety of support groups for new parents, including cesarean section mothers and obstetrically-battered women, have begun to grow in number. In New York state, legislation requiring physicians and midwives to obtain complete informed consent before administering any drug or procedure is setting an important precedent. (For a copy of this act, write to Doris Haire, c/o National Women's Health Network, 2025 I St., Suite 105, Washington, D.C. 20006.) At the FDA, on several committees, important challenges are being raised about obstetric drugs, about information given to patients in labor, and about the wording on package inserts. Change is happening, however slow and however small; the issues are being raised. And it is usually women who are making these things happen.



H.O.M.E.



Boston Globe/cpf

Can Childbirth Survive Technology?

COLE Everybody's read about the "natural childbirth" revolution. All over the country, it seems, women are giving birth in homey hospital settings, huffing and puffing their way through labor without a hint of anesthesia, delivering their babies into the supportive hands of their husbands or a midwife.

But despite all the media attention to Lamaze, La Leche, and Leboyer, the truth is that childbirth in America is getting more unnatural every day. A woman expecting her first baby today has a 25 percent chance of delivering by Caesarian. Even a "natural" birth often means that the mother is merely "awake" for the proceedings. Never mind that she's strapped down, numb below the waist, electronically monitored, chemically induced, and intravenously fed. "Natural childbirth" mothers use some form of anesthesia up to 75 percent of the time. In some hospitals, they are hooked up to fetal monitors and a variety of intravenous fluids and drugs 100 percent of the time.

Some medical schools don't even teach aspects of "natural" birth anymore, doctors say. Today's obstetrician can take technology or leave it; tomorrow's may not have a choice. "The present day obstetrical resident is an electronic wizard," says Dr. Don Sloan, an obstetrician at Lenox Hill Hospital. "You go into conference with them and nobody knows if the patient drinks or smokes or fights with her husband. But they know all about her A Scan and her B Scan. You get the feeling you're in a NASA conference."

Indeed, as evidence seems to accumulate in favor of leaving nature alone, the new technology threatens to take over the birthing business. Where technology is indicated, of course, it often saves lives. But it's most often used "just in case" it's indicated--which means all the time. And the forces pushing it are powerful: Fear, malpractice suits, and slick merchandising. The "Chef Boyardee syndrome," says Dr. Sloan, has been a major factor ever since the company that produces Chef Boyardee and Saniflush toilet bowl cleaner started producing fetal monitors: "I don't believe it's a coincidence that a sharp marketing team like American Home Products buys a monitor company and suddenly people start buying monitors."

Pediatricians, obstetricians, and patients often find themselves at odds with each other, often bitterly, over methods of delivery. "I don't pay much attention to what obstetricians say, because they make their money off it," says Chicago pediatrician and medical writer Robert Mendelsohn. "The incidence of complications of hospital births is 99 percent. The incidence of complications of home births is 1 percent."

On the other side of the delivery table is Graham G. Hawks, chief of obstetrics at New York Hospital-Cornell Medical Center. "Babies die from natural childbirth," he says. As for mothers, he cites statistics that one in 150 mothers died in childbirth in 1930. "Going back to natural childbirth will reverse us to this," he says.

Nobody disputes the fact that infant mortality in this

COLE country has been steadily declining--a powerful argument for technology. On the other hand, the U.S. still ranks only about fifteenth in infant mortality among countries--a common theme of home birth advocates. They say American hospital procedures are at fault.

"What bothers me is the lack of objectivity, the rigidity, on both sides," says Dr. Lois Lyon Newmann, director of neonatology (newborns) at New York University Hospital-Bellevue Medical Center. "I am emotionally in sympathy with natural childbirth. I would like to see technology used in a more humane way. But I am distressed by the back-to-nature movement. When things go wrong, it happens so quickly; I've seen it too many times."

What's a mother to do? She wants "natural" childbirth. But she also wants the best modern medicine has to offer. If she doesn't get it, she might sue the doctor--which puts more pressure on him to use technology whether she wants it or not.

Natural childbirth advocates say the answer is to screen out those women who probably will need the technology from the 95 percent who probably won't. "Inevitably, if there is a high-powered instrument in the hospital, it's going to be used on a healthy person," says Dr. Edward Stim, medical director of Manhattan's 78th Street Center, a home birth screening and care center. "The best control is to keep healthy women away from hospitals. Routinely giving everything to everybody is causing more and more iatrogenic (doctor-caused) illnesses."

The problem with screening is that it doesn't always work. "The home birth centers select a very low-risk population," says Dr. Newmann. "And still a significant number gets transferred to hospitals during labor, which speaks to the lack of predictability." Natural childbirth advocates say that doctors don't know how to screen because they have a vested interest in *not* learning. "The medical schools don't teach screening," says physicist David Stewart, executive director of the National Association of Parents and Professionals for Safe Alternatives to Childbirth (NAPSAC). "Any doctor who says you can't screen effectively is merely confessing his ignorance."

Ironically, the home-versus-hospital controversy is fueled to a large extent by the new childbirth technology. As more hospitals use technology routinely, more women choose to have their babies where most doctors would least like to see them--at home. Few doctors, or patients, like the alternatives. "If the choice is between an IV and a home delivery," says Long Island obstetrician Robert Fitzgerald, "and the patient chooses a home delivery, then the hospital is partly responsible." "IVs are overdone," says Morris A. Wessel, clinical professor of pediatrics at Yale Medical College. "You have women who are sitting up to ask for a cup of tea and they get an IV. So women are having babies at home."

A spot check of major teaching hospitals in New York, Boston, Pittsburgh, and Chicago revealed that IVs are standard procedure. "Without an IV, I won't deliver the patient," says Dr. Hawks. One of his students, first-year obstetrical resident Pat Yarberrry-Allen, explains why. "If I have a patient who refuses an IV, I tell her the reasons and she always goes along."

COLE I tell her that she deserves the very best the hospital has to offer; that the physicians are more comfortable if there's an intravenous line in place; that that way we have ready access in case of fetal distress or some other emergency--for example, if she should hemorrhage."

IVs are used just in case the mother should need emergency anesthesia to perform an emergency Caesarian just in case something should go wrong with the baby. They are also used to provide the mother with fluid and a source of energy (glucose) during labor. Hospitals that routinely require IVs don't allow the mother to eat or drink--just in case she should need emergency anesthesia, vomit, and choke.

But IVs are hardly conducive to "natural" childbirth. "It anchors the woman to the bed," says Dr. Stim. "It destroys her confidence, her whole attitude." In many hospitals, a patient may ask not to have an IV. But then the doctor might say he won't--or can't--treat her. "Or the nurse will say, 'What's wrong with you? You want to kill your baby?'" says Janice Greene of New York's Cooperative Childbirth Network.

Moreover, the IV is only the beginning. Fooling around with Mother Nature is hard to stop once started. "Once you get an IV, there's a tremendous temptation to inject intravenous drugs," says Dr. Stim. Most of those drugs can affect the fetus, which means it's probably a good idea to attach the mother to a fetal monitor--just in case. "Let's take a woman in labor," says Dr. William Cochran, neonatologist at Boston Hospital for Women. "In the old days, a nurse would watch that woman carefully. She'd listen to the baby's heartbeat. It was a good procedure because the nurses were so good. The new nurses are good at looking at monitors, but not very good at listening to hearts."

A fetal monitor electronically records the unborn baby's heartbeat and the contractions of the mother's uterus. It consists of a large box (or series of boxes) which stand vigil at the laboring woman's bedside. Electronic beeps and blinking lights keep time with the fetal heartbeat. A stylus draws graphs of the mother's contractions on graph paper. Her belly is encircled with a heavy strap and attached with suction cups to a plastic box. Sometimes, electrodes are implanted in the baby's head.

Monitors are standard at most major hospitals today. But they aren't standard with obstetrician Don Sloan. That's why he was upset when Lenox Hill was closed down for a week and he had to send patients to New York Hospital. "By the time I got there, they both had IVs and monitors; one had a monitor screwed into the baby's head. It's just a practice. There isn't any dictum from the board. If I asked the board why they do it, they'd say the doctors insist on it. If I asked the doctors, they'd say the nurses demand it. The nurses would say it was the patients. Then someone would say the garbage men insist on it, and before you know it, they'd be blaming it on the unions."

Studies on the use of monitors have shown that they can save babies' lives--usually by signaling the need for an emergency Caesarian section. "The evidence is pretty strong that some stillbirths can be prevented by monitoring," says

COLE Dr. Newmann. "Before we had monitors," says Dr. Fitzgerald, "I've seen babies that were lost who could have been saved."

The routine use of fetal monitors has played a major role in pushing up the Caesarian rate. "It's not the monitors themselves," says Dr. Fitzgerald. "It's the misinterpretation of the monitors. But misinterpretation is easy."

Dr. Mendelsohn reports that two major inventors of monitors have come out against them "because they've been so tremendously distorted. They're more harmful than drugs, because they've led to so many Caesarians. We call them feeble monitors."

Still the studies show that monitors are safer. The question is, safer than what? If the mother is left alone, without a well-trained nurse, without a caring obstetrician, with drugs, then she's probably better off with a monitor. "If you have bad obstetrical situations, you have better results with a monitor," says NAPSAC's David Stewart. "Monitors plus bad obstetrics is better than bad obstetrics alone."

Natural childbirth advocates say that monitors dangerously interfere with the normal process of labor by forcing the woman to lie prone and virtually immobile: they say monitors may create the very kinds of problems they're designed to detect.

But doctors don't always have a choice: "If something went wrong and the parents were told that they could have had a monitor," says Dr. Cochran, "it would have made their obstetrician look wrong."

In the end, it's often the mother who opts for the fetal monitor "just in case," and also who agrees to the Caesarian section "just in case" the signals from the monitor are serious. "It's very hard for a woman in labor to be natural with a monitor," says Dr. Cochran. "It shows a little abnormality and everybody comes in. Then she has to make the decision: Does she want to risk damage to the baby's brain? She always says no. Then the baby turns out fine, and she doesn't know if she needed that section after all."

"Here's the philosophical question you have to ask," says Robert Fitzgerald, past president of the American Society for Psychoprophylaxis in Obstetrics. "By doing more Caesarians, you have reduced fetal mortality and morbidity, but you've exposed mothers to increased mortality and morbidity. And it doesn't stop at the first section. If a woman dies of hemorrhage on her second or third section it's still the responsibility of the doctor who did the first section."

Caesarian sections are today considered so safe, so simple, that they are used routinely for everything from breech births to anything irregular that shows up on a fetal monitor. Nationally, their number has tripled in ten years. "Twelve years ago obstetricians were criticized if their C-sec rate was over 5 percent," says Dr. Cochran of Boston Hospital for Women, where the Caesarian rate is over 20 percent. "Today, if there's any kind of problem, they're criticized if they don't section that woman. So here's that poor old obstetrician, wondering why he didn't do it looking back. Twenty-five percent of the time when twins are born, obstetricians don't expect them. That's the state of the art."

COLE

And so, Caesarians are performed not only for emergencies, but also "just in case" a too-long labor might "batter" the baby's head against the mother's pelvis, causing brain damage; just in case the baby of a mother with ruptured membranes (whose water has broken) should pick up an infection; just in case a breech (feet first) presentation might pose problems for the baby.

"In the old days, doctors were proud of delivering breech babies successfully," says Dr. Cochran. "Now, the obstetrician has the heat on. If something goes slightly wrong and he didn't do a section, he was a bad, bad boy."

David Stewart of NAPSAC reports that delivering breeches has been "deleted from the curricula at many medical schools, because they can just do a C-section. They are narrowing the skills of the physician."

Indeed, first-year resident Pat Yarberry-Allen has never attended a breech birth. "We don't teach it because we don't have the opportunity," says Dr. Hawks. "Because the C-sec rate is so good."

Almost everybody agrees that Caesarians mean increased risks for mothers. According to pediatrician Mendelsohn, they're not always good for the baby either. "There's the risk of damaging the baby's lungs," he explains. "When the baby goes through the birth canal, the mother squeezes fluid out of his lungs. This doesn't happen with a C-section." Life-threatening lung deficiencies are much more common among Caesarian babies--especially when they are delivered prematurely. Prematurity goes hand in hand with another kind of technology that has many doctors worried--induced and stimulated labor.

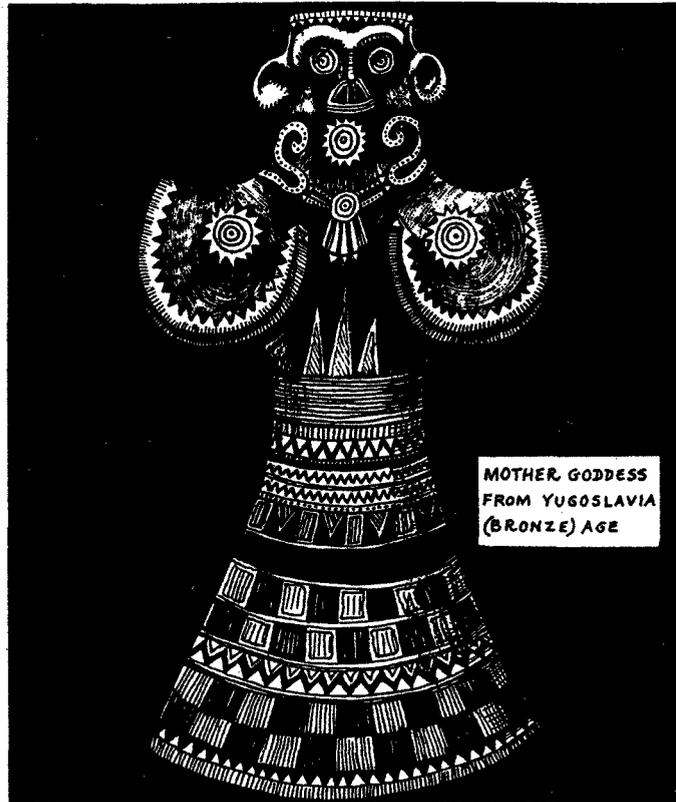
"A lot of hospitals have 9-to-5 deliveries," says Mendelsohn. "So they induce them with Pitocin."

Induced labor, like planned Caesarians, always carries the risk of prematurity. Technology has a partial answer in the form of a test for L-S ratio, an indication of lung maturity. But the same technology presents problems of its own. "Before we had the test," says Dr. Cochran, "if a mother was four weeks overdue, we'd go ahead and deliver. Now, with the test, if the ratio is low, we might wait another week. Then the baby might die--because the technology is not perfect."

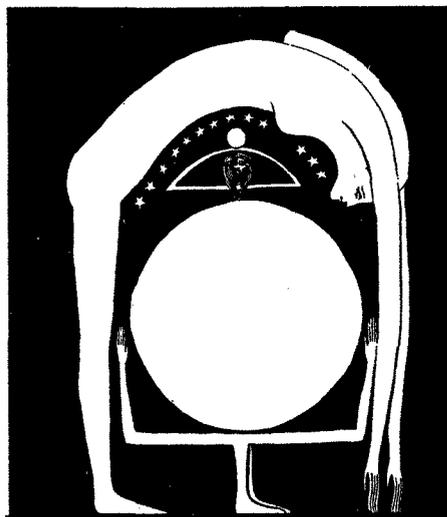
Even more common is the practice of stimulating labor to speed it up once it's started. Pitocin is one of several drugs (oxytocins) which does this. Some doctors estimate that oxytocins are used to induce or stimulate labor up to 60 percent of the time. "I know a lot of doctors who use oxytocins on every patient," says David Stewart. "Obstetricians in a hospital situation make for great impatience," says Dr. Stim. "So they speed things up. Pitocin has been called chemical forceps."

Pitocin produces stronger and faster contractions than normal labor. For the mother, this means labor hurts more. She's more likely to be unprepared for it and to need drugs.

The effects of oxytocins on the fetus can be more severe. According to David Stewart, studies in England have shown that routinely stimulated labor put more babies in the intensive care ward. "It's a main cause of Caesarians because it causes



MOTHER, GODDESS
FROM YUGOSLAVIA
(BRONZE) AGE



*Nut,
Queen of Heaven
Mother of the World*

*Each night she gives
birth to the sun
Each evening, she
swallows it, to
bear it anew.*

H.O.M.E.

COLE fetal distress."

Yale's Dr. Wessel is "uncomfortable" about the possible misuse of Pitocin in the early stages of labor. "If the cervix is not dilated, pushing the baby could be harmful." Pediatrician Mendelsohn blames stimulated labor for "the major epidemic of learning disabilities in our society."

Oxytocins increase the pain of labor, leading to the need for more anesthesia. But anesthesia can also lead to the need for oxytocins. Technology fuels its own chain reactions.

"If an epidural stops the labor, we can just use Pitocin to speed it up again," says Dr. Yarberrry-Allen, obstetrical resident.

A form of spinal anesthesia, epidurals are a favorite among doctors and women alike. They numb the mother completely below the waist, so she can witness the birth of her child without feeling an iota of pain. But she also can't feel the "urge to push" the baby out. Thus epidurals, like other forms of anesthesia, set off cycles of their own. Because the mother can't participate, and because the labor is slowed, epidurals increase the need for oxytocins, forceps, and Caesarians.

The epidural is a tricky, high-technology kind of anesthesia. Hospitals tend to use them a lot, or not at all. If the drug is injected too high, it can hit the mother's heart. And despite frequent claims to the contrary, epidurals do seem to affect the unborn child. Dr. Cochran reports that studies by Dr. John Scanlon have shown that the drug doesn't only show up in the baby's bloodstream. "It also shows up in the baby's behavior," says Dr. Cochran. "The babies are floppier."

Epidurals are used up to 90 percent of the time (at Manhasset's North Shore Hospital, for example) for Caesarian deliveries. That way, the mother can see her child as soon as it's born. Thus, for women--and doctors-- who call deliveries with epidurals "natural childbirth," a Caesarian doesn't make that much difference.

"All of these measures are prophylactic: they're all preventive," says Dr. Graham G. Hawks of New York Hospital. Last year at New York Hospital, approximately 75 percent of births involved Demerol, 37 percent forceps, 60 percent episiotomies, and an indeterminant number of catheterizations. Of those who used Demerol, "the majority are Lamaze people," says Dr. Hawks. When asked how many "completely natural" births occurred at the hospital recently, he replied, "I know only of one."

This is not surprising, since one intervention tends to lead to another. A woman usually needs a catheter if she's been oversedated and can't urinate, says Dr. Stim, or if an IV has been "pumping lots of fluids into her." Forceps deliveries tend to require catheterization, as well as bigger episiotomies--an incision in the mother to make room for the baby's head. Epidurals often require forceps, and also Pitocin, which speeds up labor so that the mother's "skin doesn't have a chance to stretch," says Dr. Cochran, so she needs an episiotomy. "I hate to see these women inching around. It takes the bloom off the rose."

Of course, nothing takes the bloom off childbirth like being separated from your baby. Isolating the mother when she

COLE runs a temperature "just in case" she should transmit something to the baby is also becoming standard hospital procedure.

"If anything has been demonstrated scientifically beyond a doubt, it's the bonding technique," says Dr. Don Sloan of Lenox Hill Hospital. "Children who are held immediately by their parents have higher IQs, better vocabulary, better growth weight, decreased infection rates."

Graham G. Hawks of New York Hospital, on the other hand, decries bonding. "With all of this bonding baloney, I don't see where it's preventing divorce or decreasing juvenile delinquency. I have two of the most wonderful children in the world; they're bound to me like glue; and I nursed them myself on a bottle."

The conditions that cause a mother's temperature to rise after childbirth include bladder infections (perhaps from a catheter), breast engorgement (when her milk comes in), a Caesarian delivery, and normal after effects of labor and delivery. Most conditions that cause fevers are innocuous.

"The problem is telling which is which," says neonatologist Newmann. "If the mother has a strep and it gets to the baby, it can cause serious complications, even death. So you tend to cast a very wide net--even at the expense of maternal-infant contact." Neonatologist Cochran disagrees: "The proof that this has ever happened is zero. We have never shown that isolating a mother did or did not get involved in transmitting infections."

Naturally, nursing mothers suffer most because separation from the baby interferes with milk production--and sets off another cycle: If the mother's running a temperature because her milk is coming in and she can't nurse her child, her temperature will go up even more.

The debate over natural childbirth is clouded by ignorance, animosity, and fear. The only thing the various factions seem to have in common is the desire for healthy mothers and babies. An obstetrician like Don Sloan, who has set up a "birthing room" at Lenox Hill, finds himself in the middle. Anti-technology spokesmen call birthing rooms "the plant on the IV pole school of obstetrics. You put up some wallpaper and do all the intervention you want."

Some of Sloan's colleagues, however, think birthing rooms are "dungeons" for hippie long-haired types. "They say, 'Sloan! What do you want? To put hay on the floor?' We don't want to go back to anything. We simply want to make these electronic empires available instantly in a setting that's acceptable to the consumer."

In between are doctors like Lois Newmann, who doesn't understand "why a strap around your belly is a reason for nurses not caring. I don't think family-centered childbirth and technology are incompatible. I've seen the fuzzy-headed doctor who doesn't believe in technology, and I don't want him taking care of me."

Unfortunately, fear, lawyers, and advertisers are pulling the forces apart, not together. The new technology is ubiquitous, effective, and tempting. It's hard for a mother or a doctor to say no to any procedure that might prevent a compli-

COLE cation or cure one "just in case" it happens. As families want fewer children, they demand perfect babies every time. Technology, it seems, can guarantee that. It can even diagnose certain kinds of "imperfect" babies before they're born.

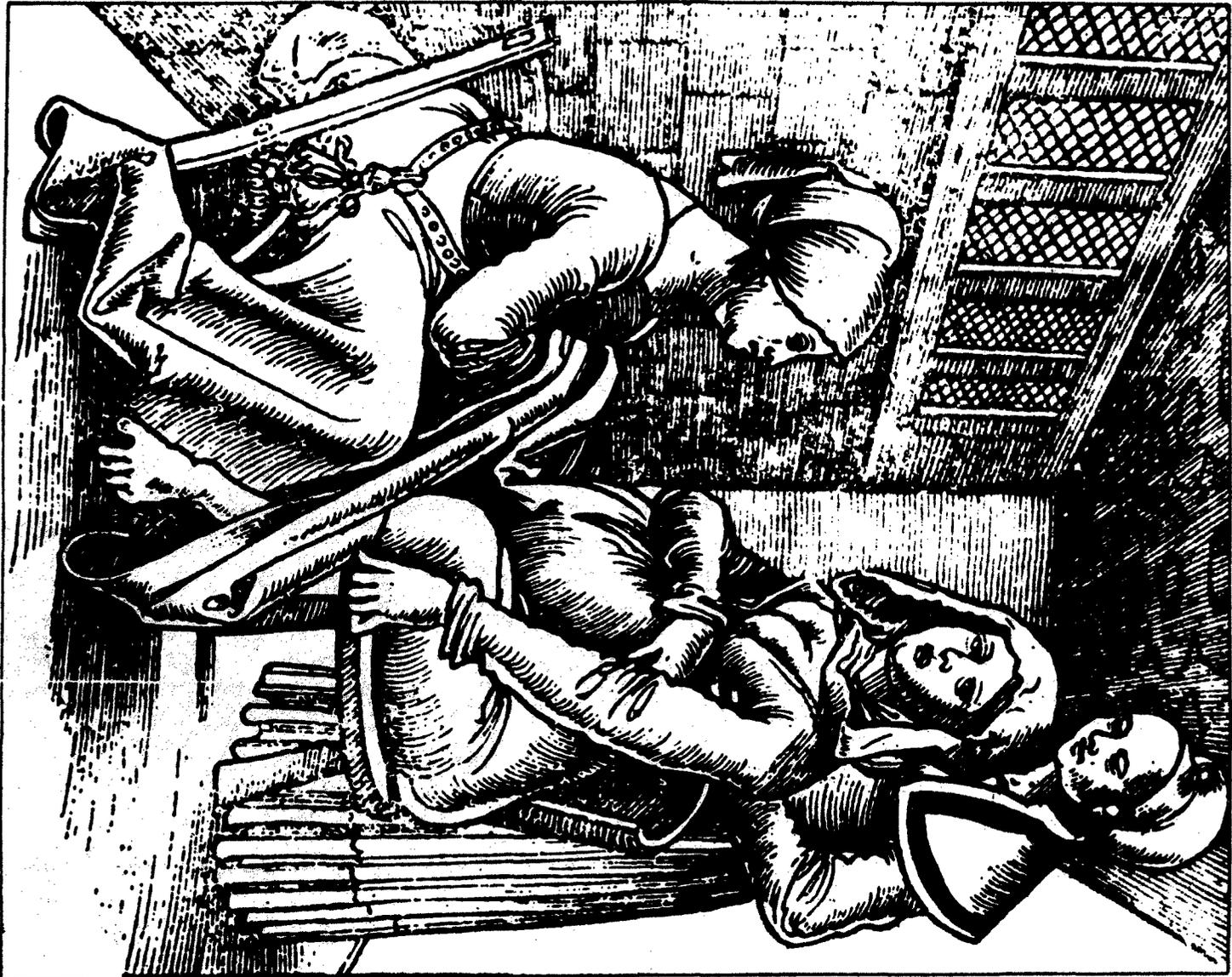
Moreover, many hospitals are advised by their lawyers to require fetal monitors and IVs for every patient. North Shore is a case in point. "Even if the patient signs a waiver," says Dr. Fitzgerald, "the lawyers have said that it might not hold up."

And then there's the Chef Boyardee syndrome: "We're victims of the same pressures our public is," says Dr. Sloan. "We buy Cadillacs and Chef Boyardee, too. The electronics wizardry is welcome on site in case we need it. Obstetrics should make every effort to modernize. My concern is that it has become the tool of Madison Avenue; that it has become the tool of malpractice litigate.

"Many hospitals think monitors are good business. I'm trying to convince them that birthing rooms are good business."



Drawing by Peg Averill/LNS.



Sister Courage/Cpf

Maternal Health

THE PROBLEM

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Introduction: Maternal Health in Relation to Women's Health: Traditionally, maternal and child health has been regarded as equivalent to women's health. Three assumptions underlie this equation: (1) that all women marry and become mothers; (2) that the health of women is of concern only insofar as women are the vehicle for the child; and (3) that women be in adequate physical condition to fulfill her "wifely duties," i.e., be healthy for intercourse and domestic chores.

Though these ideas may sound hopelessly antiquated, most experts planning in the area of women's health programs continue to operate from these assumptions, implicitly or explicitly. These ideas about the function of the woman's body are so deeply imbedded in the social fabric that they usually go unnoticed and unquestioned. Woman's role as producer and worker outside the home, and the risks to her health in other settings, are only now being considered. Plans, then, are based on stereotypes.

The women's health movement has broken down many stereotypes concerning women's bodies. Thus, we see maternal health as a subset of women's health, which is also concerned with and connected to many other issues. In the following discussion, two very different kinds of assumptions about maternal health underlie our thinking: (1) that women should have the right to choose whether they want to have children; and (2) that society should support whichever choice women make. Practically speaking, these two assumptions point to the need for women to have access to safe contraception and to safe, legal abortion services as back up to contraceptive failures, as well as safe and satisfying supports for the childbearing experience. In addition, women need health services which are comprehensive, concerned with general health and well-being, of which reproduction is only a part.

Most of us, as well as policy-makers, do not understand the general relationship among fertility control services, maternity services, and maternal health. Fundamentally, optimum health for motherhood presumes an excellent diet before pregnancy, as well as during the childbearing and breastfeeding intervals. We can best achieve optimum maternal health in a climate of sexual responsibility which includes knowledge and discussion of sexuality as well as access to fertility control information and services. Similarly, women who do choose to become pregnant need access to information that will help them to decide how and where to give birth.

As a result of society's failure to provide such information and services to all women, *socioeconomic class, race, and education largely determine maternal and infant health as well as childbearing choices*, not what medicine does. Clearly, changes in maternal and child health services could help alter this severe imbalance. However, the realities of the existing health and medical care system present many barriers to correcting problems in maternity care.

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The Role of Women in the U.S. Health and Medical Care System: Despite general agreement by public health experts that health status and longevity are much more the result of diet, exercise, rest, environment, and life-style than medical intervention or care, the U.S. system still concentrates on institutional care after a crisis has developed. Despite evidence that many procedures performed on childbearing women do not improve outcome and may even affect it negatively, the American obstetrical community continues to develop and use experimental crisis-oriented procedures and technology rather than emphasize and promote prevention and self-care.

Women are the major consumers as well as the major workers in our health and medical care system. But the system is run by policy-makers and physicians who are virtually all men and/or trained exclusively by men. Currently, less than 5 percent of the trained obstetricians and gynecologists in the U.S. are women; an even smaller percentage of those women are teaching in medical schools. The U.S. health and medical care system is one in which profit is a legitimate motive. As a result, special interest groups that do not represent consumers of services heavily influence government planners, regulators, and lawmakers.

These general observations apply more to medical services for women than to any other area of our system. Special interest groups include:

1. Obstetricians and gynecologists, particularly as represented by the American College of Obstetricians and Gynecologists (ACOG). (Obstetricians/gynecologists earn more than any other group of physicians in private practice.)
2. Pharmaceutical manufacturers and hospital equipment and supply companies, whose profits are among the highest in industry.
3. Hospital associations that work to keep hospital-based care at the center of all community health and medical activities.
4. Insurance companies and other groups that work to keep the third-party payment system (in which consumers pay indirectly for the medical care by buying insurance) at the center of the economics of the medical care system.

Until recently, these groups have been the major "spokesmen" for women's health and have been the principal architects of the existing system.

THE ISSUES

Maternity Care as Primary Care: In 80-90 percent of all cases, we can achieve the best maternity care through primary care, that is, preventive care and screening given while we are normal, before the situation develops into a crisis. Because pregnancy and childbirth are healthy conditions rather than diseases, we can prevent the vast majority of problems by proper care during pregnancy. We've come to confuse prenatal care with doctor visits. It is truly the care a woman gives to herself which determines her well-being during pregnancy and childbirth, a state of health which the medical care setting can only monitor.

SWENSON Even so, doctors rarely give major emphasis to diet and lifestyle factors.

Many studies have demonstrated that low income and non-white women are the least likely to receive prenatal care. Even when they do receive care, they have fewer prenatal visits. Inadequate self-care and prenatal care for these women may be an important cause of the higher maternal and infant mortality rates in this group.

Tom Brewer, MD, a founder of the Society for the Protection of the Unborn through Nutrition (SPUN), believes many women at all economic levels suffer from malnutrition during pregnancy. Women are placed on low-salt diets, given prescribed diuretics (drugs that lower salt and reduce fluid retention in the body), and placed on absolute weight gain restrictions--all with the intention of preventing toxemia. However, Brewer and others believe that this very method of attempting to prevent toxemia has, in fact, led to an increased incidence of toxemia and eclampsia, a serious condition of pregnancy characterized by high blood pressure, protein in the urine, edema (water retention), and convulsions, if untreated.

This method of diet control, critics contend, may lead to the birth of low-weight and brain-damaged babies. Brewer's sensible high protein diet has demonstrated that women at all class levels can avoid these problems. Despite recent studies and publicity emphasizing the dangers of low birth weight to newborns, some doctors continue to restrict calories and salt and to prescribe diuretics.

At the federal level, two programs have attempted to improve the nutrition of low-income women and children. Both programs have been hampered or designed in such a way as to be partially ineffective. The Women and Infant Care program (WIC), authorized by Congress in 1972, is a community-based program which, while having the proper intent, has failed to reach many of the people at the lowest income levels who need the program the most. A further problem with the WIC program is that plans are underway to move the program out of the community where it has been based and into the hospital, thereby further emphasizing the crisis view of pregnancy and childbirth.

Similarly, the Maternity and Infant Care program (MIC) has reached very few of those who need it most. The MIC program tries to provide specialized, comprehensive pre-natal and post-partum services to women at high-risk of developing complications during pregnancy and delivery. These women are poor, largely but not exclusively minority women. The program is currently offered through health clinics. The hours and locations of these clinics are not necessarily accessible to working women and/or women with several children. MIC results are uneven.

The result of an overall failure to develop successful comprehensive programs of preventive, primary care for all women has been continuing decline in the U.S. ranking in both maternal and infant mortality as follows:

1. The overall maternal mortality rate (MMR) in the U.S. is considerably higher than in Sweden and Scotland. For non-white women, the rate is nearly eight times higher than in Sweden and Scotland. For non-white U.S. women the rate

continues to be about three times that for U.S. white women. Most maternal deaths are anesthesia-related.

2. The overall infant mortality rate (IMR) in the U.S. is currently twelfth in the world (1975 data). In other words, eleven other countries, have lower infant mortality rates than we do. The death rate for U.S. non-white babies is twice that of white babies.

The greatest percentage of babies who die as newborns do so during the first day of life in the hospital while under the care of doctors and nurses. The major causes of infant mortality are prematurity and low-birth weight, both of which are largely preventable. The greatest numbers of these births are to very young, very poor, and/or non-white women who receive neither adequate nutrition nor sufficient prenatal care. Frequently, they do not receive appropriate care during labor and delivery. While our IMR has stabilized recently, relative to other countries, our birth rate has also continued to fall. Other countries with better rates spend far less than the U.S. on health care, particularly maternity care. We should be able to use our massive resources to ensure that the few babies now being born are born healthy.

Other Problems in the Existing System: Four other important areas of maternity care services need to be changed before women can be assured of receiving the care that they deserve in giving birth to healthy children: (1) the drastic revision of prenatal and hospital-based care which increasingly leads to complications in labor and delivery; (2) the provision of appropriate back-up supports for women giving birth in birth centers or at home; (3) the reinstatement of midwives as the primary care attendants

Perinatal and maternal mortality in various countries

	Perinatal mortality		Maternal mortality per 1 000 000 births
	1969	1973	
United States	27.1		24.5
England and Wales	23.7	21.3	19.4
Scotland	25.6	22.7	14.4
Northern Ireland	29.2	25.9	15.4
Republic of Ireland	27.0		31.8
Sweden	16.3	12.9 (1974)	10.2
Norway	20.7	16.8	14.8
Finland	18.9		14.8
Netherlands	19.6	16.4	19.4
Belgium	25.1		20.5
France	25.4		24.9
Italy	32.4		60.6
West Germany	25.2	23.2	53.1
Switzerland	19.5	15.5	29.3

† Perinatal mortality is the rate per 1000 births of still births of more than 28 weeks of gestation, together with liveborn infants that die within the first week of life. Maxwell (1974)

SWENSON for the majority of pregnant and childbearing women; and (4) universal availability of birth control and abortion services.

The need for these changes has been abundantly documented in numerous studies, papers, and demonstration projects, many of which have been conducted by the medical profession itself. The extensive bibliography at the end of this *Guide* points the reader to material that is available on this subject.

THE FUTURE

Changing the Existing System: As pointed out above, special interest groups control policy decisions about U.S. maternity care. The campaign to retain this control in the hands of physicians has received support from both federal and state governments. Policy-makers are still advocating higher technology, the closing of small maternity units, the consolidation of maternity services in very large regional centers, and the relegation of midwives to the status of assistants to physicians. When fully implemented, such a plan would effectively deny parents the choice of where, how, and with whom they can give birth. In some states, there are no existing alternatives to hospital birth; in many others, there is organized opposition to alternatives. In many states, midwifery practice is limited to hospital births.



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Until recently, consumer efforts to change the direction of maternity care have focused on the practice of individual doctors and hospitals. However, consumer and women's groups have recently begun to cooperate in influencing policy-making at state and federal government levels. Such efforts can not only preserve freedom of choice in childbirth but can also strengthen the entire field of women's health.

Parents and other interested consumers can work in three important areas to change existing maternal care and maternity services:

1. By joining local women's groups, women's health center and advocacy groups, and childbirth groups, nearly all of which have links with other groups across the U.S., through national organizations. Many of these groups are attempting to influence policy at the state and national levels. Parents seeking an optimum birth experience can insure the greatest options through these groups. (See Directory.)
2. By joining local Health Systems Agencies (HSAs) which are federally-funded, consumer-dominated, private organizations mandated to plan health services and facilities in every state and region. It is in these settings that much of the new maternal and child health policy of the region and ultimately the state is formulated. There are also national consumer groups for HSA members. (See Directory.)
3. By joining the National Women's Health Network which is working to change all policies that affect women's health. Both groups and individuals are members of the Network. State and local groups with similar goals may become part of the Network in the near future.



The Childbearing Center

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In 1975, after two and a half years of preparation, Maternity Center Association (MCA) opened its most recent and perhaps most controversial demonstration, the Childbearing Center (CbC), which was designed to test whether safe, satisfying and economic out-of-hospital care might meet the needs of those families employing "do-it-yourself" home delivery. Our 27 years of experience (1932-1958) with professionally conducted home birth had demonstrated that with careful screening and management which focuses on prevention and early detection, birth can be safely accomplished outside the hospital setting.

To meet the needs of today's family, and to avoid the high costs of systematized home birth, we developed an out-of-hospital unit, operated by a multi-disciplinary team offering comprehensive care to healthy families anticipating a normal birth experience. The fact that the unit is a maxi-home and not a mini-hospital must be emphasized. In other words, our starting point is the home, with all it offers in the way of emotional support, comfort, and security.

To our homelike setting, we add some of the supports which enable emergencies to be expeditiously handled, such as oxygen, blood volume expanders, resuscitation equipment, maternal and neonatal emergency drugs, a neonatal transport isolette, and an ambulance transfer system to a nearby back-up hospital. We have not used hospital care as a starting point. Hospital modalities necessary for complicated pregnancy and birth, such as pitocin induction or augmentation, fetal electronic monitoring, general anesthesia and forceps are not utilized in the Childbearing Center for the reason that they carry their own inherent risks.

Team members in the Childbearing Center include obstetricians, nurse-midwives, nurse-midwife assistants, pediatricians, public health nurses and ancillary and support personnel. Full maternity care is provided. Prenatal care is strongly rooted in education and is prevention-oriented. Deliveries are accomplished in the Center and families return home in up to 12 hours following birth. There are two home visits by public health nurses in the first week, the first within 24 hours of the families' return home. Families return to the center in the first and sixth postpartum weeks for examination. Staff members are available at all times for telephone consultation.

For families interested in our care, the process at the Center begins when they inquire, either in person or by telephone. At that time, initial screening relating to age (i.e., 35 or over for first baby, or 39 or over for second through fourth babies, rules out); obstetrical history (i.e., previous cesarean section rules out); physical health (i.e.,



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cardiac disease or diabetes rules out); and gestation (families are not accepted after the 22nd week) is accomplished and an inquiry form is filled out.

All families, whether eligible at that point or not, are invited to attend an orientation to the Center. (Three are held each week; professionals are welcome.) During the orientation, which is required for potentially eligible families, the operation of the CbC and its opposition by organized medicine are fully discussed; questions are answered and a tour of the unit is conducted.

The CbC is located on two floors of a Manhattan town house, formerly the home of a prominent merchant. At street level, there is a reception area, office, multi-purpose room for meetings and/or child care, examining room, small lab and an interview room. Two bathrooms complete the layout. The intrapartum unit is on the garden level and contains two colorfully decorated labor/delivery rooms, utility rooms complete with autoclave, a kitchen, nurse-midwifery station, bath, shower, and emergency equipment alcove. On the same level, but outside the self-contained intrapartum unit, is a room where families can be together in early labor, an examining room, and an additional bath. The garden can also be utilized in early labor.

Following the orientation, families are encouraged to "shop" further and to discuss their plan to utilize the CbC with their gynecologist and "important others" before coming to a decision. When a family decides to have the physician screening, an appointment is made and they are sent history forms to fill out, a four-page general consent form with glossary to read and other information about classes, fees, etc. At the appointment, a nurse-midwife reviews the forms with the family and the consent is signed. An obstetrician does the initial physical as well as a check at the 36th week. Our prenatal care is supervised by the staff nurse-midwives.

In our experimental Self Help Education Initiation in Childbirth (SHEIC) program, families do their own physical care and recording of data in a classroom context. Fathers or other support persons are taught blood pressure estimation, abdominal palpation, fundal height measurement, and the checking of fetal heart tones. Mothers test their own urine and record their weight, plotting it in their records. Nurse-midwives review, supervise, and if necessary check findings. Any deviation from normal initiates consultation with one of the obstetricians. Our philosophy is that families, when provided with principles and guidance, will faithfully follow through. Eventually, they must care for their child. Learning to take care of the fetus is the best preparation for developing the confidence to successfully complete the child-rearing task.

When lab results from the first examination are reviewed along with physical findings and the program's management

criteria are satisfied, the family is fully accepted with the understanding that rescreening takes place at every visit. Three early classes are scheduled, one each in nutrition, touch and relaxation, and changes in pregnancy. Arrangements are made for additional instruction in childbearing and infant care, either in SHEIC or the more traditional classes held separately from physical prenatal care.

The fee for comprehensive care is currently \$885 and represents, as nearly as we can estimate, self-support for our unit when 450 families enroll per annum. The fee covers all charges including the professional care provided by the medical team staff. Circumcision alone is an extra. Any tests not required by all families are additional (i.e., Rh titre). Beyond the two visits mentioned, obstetricians serve as consultants, and, perhaps, if the family desires, as back-up in the event transfer (to a hospital) becomes necessary. Pediatric care must be selected by the 28th week of pregnancy even though our staff pediatrician will see the baby before the family leaves our setting. We do not provide well-baby care.

Labor proceeds on an at-home ambulatory basis as long as possible. After families do come into the Center, they are encouraged to be up and about in the family room. When the mother is admitted to one of the two labor/delivery rooms, prepared family members including children may accompany her. No routine procedures for management (of labor) are used. Mothers labor in a position of comfort and deliver their infants in the labor bed. Although available, analgesia is seldom used. Oral fluids are encouraged and families bring in their own food for celebrating after the birth. The healthy infant is never separated from the parents and may be cuddled and fed ad lib. The pediatric exam is performed in the presence of the parents.

We consider the demonstration, which opened in October, 1975, to be still in its formative stages. Criteria, protocols, staffing, and educational patterns are under constant review.

Interest in the Childbearing Center has grown rapidly over the two and one-half years of its existence. As the home birth movement has spread, representatives of parent groups and professionals have come to Maternity Center Association's demonstration project to discuss its operation and to explore alternatives for the families they serve. We have shared our experience with over 800 doctors, nurse-midwives, nurses, health educators, social workers, psychologists, administrators, parents, and others from this country and abroad. Increasingly, requests have come to us from health department officials seeking advice as to how to provide legally for the birth center concept in order to ensure the safety of the childbearing public.

Certainly birth centers in and of themselves cannot be

considered safe or unsafe. However, experience to this point in our unit has demonstrated safety. We have had 275 births in the CbC. About one in five presenting for intrapartum care does not give birth in-house. The most often found reasons for transfer to hospital are: failure to progress in labor, development of hypertension, and meconium staining. (We transfer for staining even if fetal heart tones show no aberration.)

Approximately 70% of our families are non-parous (no previous pregnancies) and almost half are between the ages of 25 and 29. About one-third of the families seeking our care transfer at some point. They may be either ineligible at first visit, be transferred due to no longer meeting criteria at some point (i.e., breech presentation, twins, postmaturity, rupture of membranes with no labor in 12 hours), or withdraw from the program. To date, we have had none of the feared emergencies -- abruption, cord prolapse, or postpartum hemorrhage. In 1976, two families who transferred to in-hospital care prior to the onset of labor did experience neonatal loss. Those events were thoroughly investigated and we were noted to have used good medical judgement in both instances. Late in 1977, one infant delivered in-house expired suddenly at home; that event which is still under investigation was originally diagnosed as sudden infant death syndrome.

All transfers to hospital in labor or postpartum have done well. Nine infants were transferred, five for mild respiratory distress, two for birth weight under 2500 grams, and one each for an appearance of clinical post-maturity and the possibility of sepsis (infection). Seventy-six percent of the babies have had Apgar scores of 9 or 10 at one minute and 87% had scores of 10 at 5 minutes. The lowest one minute score was in the 4-6 range (one infant) and the lowest 5 minute score was 8. All families have returned for the seventh day check; one family did not keep the six weeks appointment because they moved from the area.

In our experience, then, childbearing centers are a solution for a carefully screened "normal" population. The absolute size of that population is still undetermined. Explorations of feasibility and interpretation to the community require the efforts of a team consisting of interested and supportive experts in obstetrics and maternity care as well as consumers.

--Excerpted from "The Out-of-Hospital Homelike Setting as an Alternative for Meeting the Needs of Childbearing Families," 1978, by Ruth Watson Lubic, C.N.M., M.A., and Eunice K.M. Ernst, C.N.M., M.P.H. Reprinted with permission.

(Editor's Note: Since this paper was written, the Center has had 18 more months of experience. New data are presented in the article by Faison, Pisani, et al., 1979. See Bibliography and References.)

Parents turn to out of hospital births

—by Judy Norsigian

Increasingly, parents all across the country are choosing to give birth to children outside of the hospital, whether it be in a birth center or in their own home. In California, in at least a few counties 15% of the births take place at home. Why is this happening? And why are more and more women seeking midwives rather than obstetricians to attend their births?

To anyone who has not kept up with the latest childbirth literature, it may seem strange that any parents would want to desert the hospital setting with all its modern technology. However, as one couple recently put it: "When you really scrutinize the hospital scene, you find that it's not necessarily as safe as you'd like to think. Most of us don't know about the risks of infection and of certain routine obstetrical interventions such as the use of anesthesia and analgesia, induction, use of forceps, and electronic fetal monitoring. We need to consider these risks when choosing where to give birth."

Actually, concern about such risks is only one reason for the surging interest in out-of-hospital birth. Some other reasons are: the desire of parents to maintain an active role throughout childbirth, including minimal or no separation of the mother from her infant immediately after birth; a growing awareness of the special skills of midwives and of their excellent record in attending childbearing women in birth centers and in the home; an increasing number of studies which document the safety of homebirth and birth-center alternatives for low-risk women; and, of course, the fact that these alternatives are much, much cheaper than the hospital.

One might argue that these concerns and interests of parents could be accommodated by changing hospitals: by reducing the numbers of inappropriate interventions, by making hospital routines more flexible to allow for greater family unity and parent control, and so forth. In fact, currently some of these changes have occurred in a variety of "family-centered maternity programs" in hospitals around the country. However, in many cases the parents and professionals who have been struggling to create such programs either fail or find themselves dissatisfied with the results. These are the people who are gathering together in greater and greater numbers at conferences like those sponsored by NAPSAC (The National Association of Parents and Professionals for Safe Alternatives in Childbirth), whose third annual meeting in May 1978 drew 1500 participants. NAPSAC receives several thousand inquiries every year from all parts of the country.

Many obstetricians are disturbed by the trend to give birth outside of hospitals, believing this to be unsafe even for low-risk women. They argue that there is always the possibility of unforeseen complications that are best handled in the hospital setting. In response to such objections it must be pointed out that there are very few true obstetrical emergencies, emergencies which require in a matter of minutes the technology available in a hospital. In most situations when a complication arises, there is ample time to reach a hospital before there is any great threat to either mother or baby. However, it is true that there are risks to out-of-hospital birth, just as there are risks to in-hospital birth. The important issue there is not to prove that one setting is necessarily better than

another, but to point out that a controversy exists and that parents have the right to decide for themselves which risks they want to take when choosing where and how they want to give birth. Unfortunately, this right is not acknowledged to most obstetricians and hospital administrators, so that parents and medical professionals who are interested in safe alternatives to hospital birth often do not have the hospital back-up arrangements they need.

In New York City we find a good example of this problem. There, in 1975 the Maternity Center Association opened an out-of-hospital birth center, which employs a thorough prenatal screening program to admit only low-risk women to their center. After 2½ years of operation, the Center's record of safety has been near impeccable. Despite glowing statistics, however, harassment of the Center still continues from segments of the medical community.

Regardless of what most obstetrical authorities say, many parents will continue to plan their births outside of hospitals. There is just no documentation that for low-risk women these alternatives are any less safe than the hospital. Hopefully, hospitals and obstetricians will recognize their responsibility to provide back-up in these situations.

How can we sum up what is happening now in the arena of childbirth? Very briefly, so-called "medical" issues, that is, issues about which laypersons supposedly cannot make sound medical judgments, are becoming politicized. Given that few parents have access to full information about the risks and benefits of all birth alternatives, and that basic human rights are being denied, such politicization seems to step in the right direction. The resolution of this political struggle will have great impact on how our future generations come into this world.

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New Women Physicians: Our Best Hope?

In the August 1978 *American Journal of Public Health*, "The Future Impact of Women Physicians on American Medicine" is assessed by Dr. Naomi R. Bluestone. She contends that "one major phenomenon that clearly has the potential for effecting change in health care is the overwhelming increases in the number of women entering the nation's medical schools . . . Fifteen years ago, only six percent of incoming freshmen medical students were women." Now, the number is closer to 30 percent. Aside from the increase in their numbers, the new women physicians differ from their predecessors in some important ways. They "are choosing more and more to go into private practice, are working longer hours, are more insistent upon recompense, and are moving into more varied disciplines, including surgery and its subspecialties."

After describing the two groups in more detail, Bluestone suggests that there are three determinants of women's success in changing medicine now. Briefly, there are the extent of the backlash "in one of men's most powerful fiefdoms," "the strength and magnitude of the cooptive forces," and "the flexibility and fortitude with which women react to the above."

Damara's Birth

LUCE Our decision to have a home birth was both simple and very complex. It was simple in that from the very beginning of this pregnancy it never entered our heads that this baby would be born anywhere but in our own home. It was complex in that the decision to do this represented personally a stage of growth and awareness of many issues, social, philosophical, political, and even religious. These were related to my sense of being a woman, being in touch with and responsible for my own body. It had to do with Tom's and my sense of family, of the naturalness of life, of birth, of sexuality. We were learning slowly and somewhat painfully, but gladly, a sense of the seasons of things. We wanted our children to learn these things naturally from the early years of their lives. Being part of Damara's birth in our own home with our friends we felt was a way of doing this. We wanted to have a real choice about how we gave birth, where, and with whom. We wanted to shape and create the environment our child would be born into. We wanted her birth to be a celebration. We wanted her to be born in a happy, colorful, yet peaceful place. I wanted music for labor and people to support me and celebrate with us. Mostly we didn't want the rhythm of our family life disrupted by separation from each other or from Jonathan and Peter.

We also had developed strong feelings about what technology poorly used and institutions which become ends in themselves can do to depersonalize, dehumanize, and in many ways take from us the most basic and for some of us the peak experiences of life, like birth--and death. They become so removed from us that we don't even experience them. I had felt painful ruptures in the births of my other two children and had been able to reflect on what happened and why it shouldn't again. Most painful had been that initial ten to fourteen hours separation, routine in most hospitals. My best instincts told me that the initial contact and being together was critical and that separation was no less painful for the one being born. At home we knew there would be no separation. As it turned out, it was those first few hours of skin-closeness and warmth that were most precious to me and to Tom.

In deciding to have a home birth, we had to deal with the possibility that something could go wrong (as it could in the hospital, although we are led to believe otherwise), meaning we had to deal with death, the possibility of death. Our sense was that the quality of life is as important an issue as the fact of life, that how we birth is as important as birth.

Damara is our last biological child. We wanted to end with a bang by bringing all we were and knew to make her birth our very own experience that would be as rich as possible.

And it was: it was rich and it was uniquely ours. Most amazing had been how in touch with my body and its messages I had become. I knew the baby was coming. Awaking at midnight out of a deep sleep (My body had told me to go to bed at 8:00),

LUCE finding myself in labor, my energies were totally directed. I knew the baby was coming and coming soon. The memory of her two and a half hour journey is filled with images, feelings, sounds. The long hot bath I took, the water soothing, relaxing, easing the intensity of the contractions. Peter, our two year old, resting his head on my lap as I labored, sitting on the rug while Tom fixed the bed, vacuummed the rug (tried to--I protested, at this point, a little lint wouldn't hurt anyone), and set up the stereo. And then the music, soft beautiful in the background, totally concentrated out during contractions. It was September 25, 1974. The first cold night of the fall. I will always remember hearing, "Try to remember the kind of September/When life was slow and oh, so mellow/ When grass was green and grain so yellow." It seemed to come on just for me. The words, "Without a hurt the heart is hollow," spoke to my labor, the intensity of the very powerful thing happening within me. And there was the support I felt in between contractions from the people who were with me.

And there were the funny things. Christina, my friend, saying I did not look comfortable. My response being, what did she expect? I wasn't and couldn't imagine being so until it was over. Her asking if I'd like a bigger clock to watch (I had become wedded to Tom's wristwatch); my answering emphatically, "No, if it were bigger it would take longer for the seconds to go by!" For me, time was of the essence; to experience completely the sensations of labor, knowing they only came a minute at a time. It was good being able to drink all I wanted when thirsty, a sharp contrast to my hospital labors. I had thought of everything. Even the three thirty-five cent lollipops from Brigham's: one for Jonathan, one for Peter, and one for me. Mine went untouched. There was the birth itself. The still excitement I felt in the room; Jonathan and Peter's intent gazing, my own excitement and eagerness to push, and then the shock of the pain (those good old posterior presentations). I just pushed and pushed. I remember voices gently saying, "Push, push, you can do it." It was like everyone was pushing with me. I remember the strength of Tom holding me, voices again; "It's a girl, it's a girl." There she was, quiet and still and so beautiful. She waited before she breathed. I can still hear Cynthia saying, "Come on, little girl, breath for us." And she did. Our fingertips touched as she let out a little yell. All was quiet and peacefulness and so much welcoming. I felt all my energy had drained into her. The intensity of the feelings that followed in those hours, in the next few days, were such that they overshadowed the events themselves. But I remember the wine, the music, the song, "Moments To Live By," Tom had practiced for months ahead of time. And there was Peter's request for "Old McDonald" that had to come first.

Everyone left as quickly and quietly as they came. It was 4:00 A.M., and we were left with Peter sleeping on the floor next to our bed. Jonathan was back in bed. Tom and I lay there with Damara between us, her skin touching both of ours. Tom slept, but I lay there and watched the changes that each moment brought in her and in me. I was joyful and grateful. Through our window I watched the sun rise. Outside our room

LUCE were beautiful wild yellow flowers silhouetted against the predawn sky. They turned yellow and then almost golden as they blew gloriously in the autumn breeze. The sun rose and we rose. The day was such a celebration. Family and friends came and feasted on turkey and heard of Damara's birth as if there had never been another birth. The days that followed were a time of rest and reflecting on all that had happened. I thought of how Damara would someday share in her own birth in a way I never knew of mine, a birth that was hers and no one else's. There was hope that this would be a point where we could again touch as she moved one day into womanhood.

The second day was warm and sunny. Tom and I buried the placenta next to our house. We planted a yellow chrysanthemum over it to remind us always of the pain and joy that was Damara's birth, to remind us of the golden days of September, to remind us that "without a hurt the heart is hollow," to remind us of the oneness of life and creation (Life is birth but it is rebirth, too). To remind us, for others, that birth is one of the moments we are given to live by, and it shouldn't be taken from anyone.



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The Pregnant Patient's Bill of Rights

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The National Women's Health Network* seeks to educate women to their right to be informed of the risks, benefits, areas of uncertainty and alternative treatments regarding drugs and procedures administered to them not only during pregnancy, labor, birth and postpartum but throughout life.

Most women are not aware of their right of informed consent to medical treatment or of the obstetrician-gynecologist's legal obligation to obtain their informed consent to treatment. The American College of Obstetricians and Gynecologists has clearly defined the patient's right of informed consent in the following excerpts from pages 66 and 67 of its *Standards for Obstetric-Gynecologic Services*.

"It is important to note the distinction between 'consent' and 'informed consent'. Many physicians, because they do not realize there is a difference, believe they are free from liability if the patient consents to treatment. This is not true. The physician may still be liable if the patient's consent was not informed. In addition, the usual consent obtained by a hospital does not in any way release the physician from his legal duty of obtaining an informed consent from his patient.

"Most courts consider that the patient is 'informed' if the following information is given:

- The processes contemplated by the physician as treatment, including whether the treatment is new or unusual.
- The risks and hazards of the treatment.
- The chances for recovery after treatment.
- The necessity of the treatment.
- The feasibility of alternative methods of treatment."

"One point on which courts do agree is that explanations must be given in such a way that the patient understands them. A physician cannot claim as a defense that he explained the procedure to the patient when he knew the patient did not understand. The physician has a duty to act with due care under the circumstances; this means he must be sure the patient understands what she is told."

"It should be emphasized that the following reasons are not sufficient to justify failure to inform:

1. That the patient may prefer not to be told the unpleasant possibilities regarding the treatment.
2. That full disclosure might suggest infinite dangers to a patient with an active imagination, thereby causing her to refuse treatment.
3. That the patient, on learning the risks involved, might rationally decline treatment. The right to decline is the specific fundamental right protected by the informed consent doctrine."

**The National Women's Health Network is a non-profit coalition of 400 key women's health groups, individual consumers and health providers.*

THE PREGNANT PATIENT'S BILL OF RIGHTS

American parents are becoming increasingly aware that well-intentioned health professionals do not always have scientific data to support common American obstetrical practices and that many of these practices are carried out primarily because they are part of medical and hospital tradition. In the last forty years many artificial practices have been introduced which have changed childbirth from a physiological event to a very complicated medical procedure in which all kinds of drugs are used and procedures carried out, sometimes unnecessarily, and many of them potentially damaging for the baby and even for the mother. A growing body of research makes it alarmingly clear that every aspect of traditional American hospital care during labor and delivery must now be questioned as to its possible effect on the future well-being of both the obstetric patient and her unborn child.

One in every 35 children born in the United States today will eventually be diagnosed as retarded; in 75% of these cases there is no familial or genetic predisposing factor. One in every 10 to 17 children has been found to have some form of brain dysfunction or learning disability requiring special treatment. Such statistics are not confined to the lower socioeconomic group but cut across all segments of American society.

New concerns are being raised by childbearing women because no one knows what degree of oxygen depletion, head compression, or traction by forceps the unborn or newborn infant can tolerate before that child sustains permanent brain damage or dysfunction. The recent findings regarding the cancer-related drug diethylstilbestrol have alerted the public to the fact that neither the approval of a drug by the U.S. Food and Drug Administration nor the fact that a drug is prescribed by a physician serves as a guarantee that a drug or medication is safe for the mother or her unborn child. In fact, the American Academy of Pediatrics' Committee on Drugs has recently stated that there is no drug, whether prescription or over-the-counter remedy, which has been proven safe for the unborn child.

The Pregnant Patient has the right to participate in decisions involving her well-being and that of her unborn child, unless there is a clearcut medical emergency that prevents her participation. In addition to the rights set forth in the American Hospital Association's "Patient's Bill of Rights," (which has also been adopted by the New York City Department of Health) the Pregnant Patient, because she represents TWO patients rather than one, should be recognized as having the additional rights listed below.

1. *The Pregnant Patient has the right*, prior to the administration of any drug or procedure, to be informed by the health professional caring for her of any potential direct or indirect effects, risks or hazards to herself or her unborn or newborn infant which may result from the use of a drug or procedure prescribed for or administered to her during pregnancy, labor, birth or lactation.
2. *The Pregnant Patient has the right*, prior to the proposed therapy, to be informed, not only of the benefits, risks and hazards of the proposed therapy but also of known alternative therapy, such as available childbirth education classes which could help to prepare the Pregnant Patient physically and mentally to cope with the discomfort or stress of pregnancy and the experience of childbirth, thereby reducing or eliminating her need for drugs and obstetric intervention. She should be offered such information early in her pregnancy in order that she may make a reasoned decision.
3. *The Pregnant Patient has the right*, prior to the administration of any drug, to be informed by the health professional who is prescribing or administering the drug to her that any drug which she receives during pregnancy, labor and birth, no matter how or when the drug is taken or administered, may adversely affect her unborn baby, directly or indirectly, and that there is no drug or chemical which has been proven safe for the unborn child.
4. *The Pregnant Patient has the right* if Cesarean birth is anticipated, to be informed prior to the administration of any drug, and preferably prior to her hospitalization, that minimizing her and, in turn, her baby's intake of nonessential pre-operative medicine will benefit her baby.

5. *The Pregnant Patient has the right*, prior to the administration of a drug or procedure, to be informed of the areas of uncertainty if there is NO properly controlled follow-up research which has established the safety of the drug or procedure with regard to its direct and/or indirect effects on the physiological, mental and neurological development of the child exposed, via the mother, to the drug or procedure during pregnancy, labor, birth or lactation — (this would apply to virtually all drugs and the vast majority of obstetric procedures).
6. *The Pregnant Patient has the right*, prior to the administration of any drug, to be informed of the brand name and generic name of the drug in order that she may advise the health professional of any past adverse reaction to the drug.
7. *The Pregnant Patient has the right* to determine for herself, without pressure from her attendant, whether she will accept the risks inherent in the proposed therapy or refuse a drug or procedure.
8. *The Pregnant Patient has the right* to know the name and qualifications of the individual administering a medication or procedure to her during labor or birth.
9. *The Pregnant Patient has the right* to be informed, prior to the administration of any procedure, whether that procedure is being administered to her for her or her baby's benefit (medically indicated) or as an elective procedure (for convenience, teaching purposes or research).
10. *The Pregnant Patient has the right* to be accompanied during the stress of labor and birth by someone she cares for, and to whom she looks for emotional comfort and encouragement.
11. *The Pregnant Patient has the right* after appropriate medical consultation to choose a position for labor and for birth which is least stressful to her baby and to herself.
12. *The Obstetric Patient has the right* to have her baby cared for at her bedside if her baby is normal, and to feed her baby according to her baby's needs rather than according to the hospital regimen.
13. *The Obstetric Patient has the right* to be informed in writing of the name of the person who actually delivered her baby and the professional qualifications of that person. This information should also be on the birth certificate.
14. *The Obstetric Patient has the right* to be informed if there is any known or indicated aspect of her or her baby's care or condition which may cause her or her baby later difficulty or problems.
15. *The Obstetric Patient has the right* to have her and her baby's hospital medical records complete, accurate and legible and to have their records, including Nurses' Notes, retained by the hospital until the child reaches at least the age of majority, or, alternatively, to have the records offered to her before they are destroyed.
16. *The Obstetric Patient*, both during and after her hospital stay, has the right to have access to her complete hospital medical records, including Nurses' Notes, and to receive a copy upon payment of a reasonable fee and without incurring the expense of retaining an attorney.

It is the obstetric patient and her baby, not the health professional, who must sustain any trauma or injury resulting from the use of a drug or obstetric procedure. The observation of the rights listed above will not only permit the obstetric patient to participate in the decisions involving her and her baby's health care, but will help to protect the health professional and the hospital against litigation arising from resentment or misunderstanding on the part of the mother.

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LABOR. Serious Business Company, 1609 Jaynes St., Berkeley, CA 94703.

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LYNN AND SMITTY. Boston Association for Childbirth Education. 273 N. Ave., Weston, MA 02193. 20 min.

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ASSOCIATIONS CONCERNED WITH CHILDBIRTH EDUCATION AND
CHILDBEARING RESOURCE CENTERS
American College of Nurse-Midwives, 1012 Fourteenth St., NW,
Suite 801, Washington, D.C. 20005.

American Foundation for Maternal and Child Health, Inc., 30
Beekman Pl, New York NY 10022.

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Bookstore, c/o Sue Cockett, R.D. 9 Fair St., Carmel, NY
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Birthplace, Gainesville, FL 32601

Cesarean Support, 414 N. Cass Ave., Westmont, IL 60559, and
14 E. 60th St., Downer's Grove, IL 60515.

C/SEC: Cesareans/Support, Education, and Concern, c/o Melissa
Foley, C/SEC, 66 Christopher Rd., Waltham, MA

H.O.M.E., 511 New York Ave., Takoma Park, Washington, D.C.
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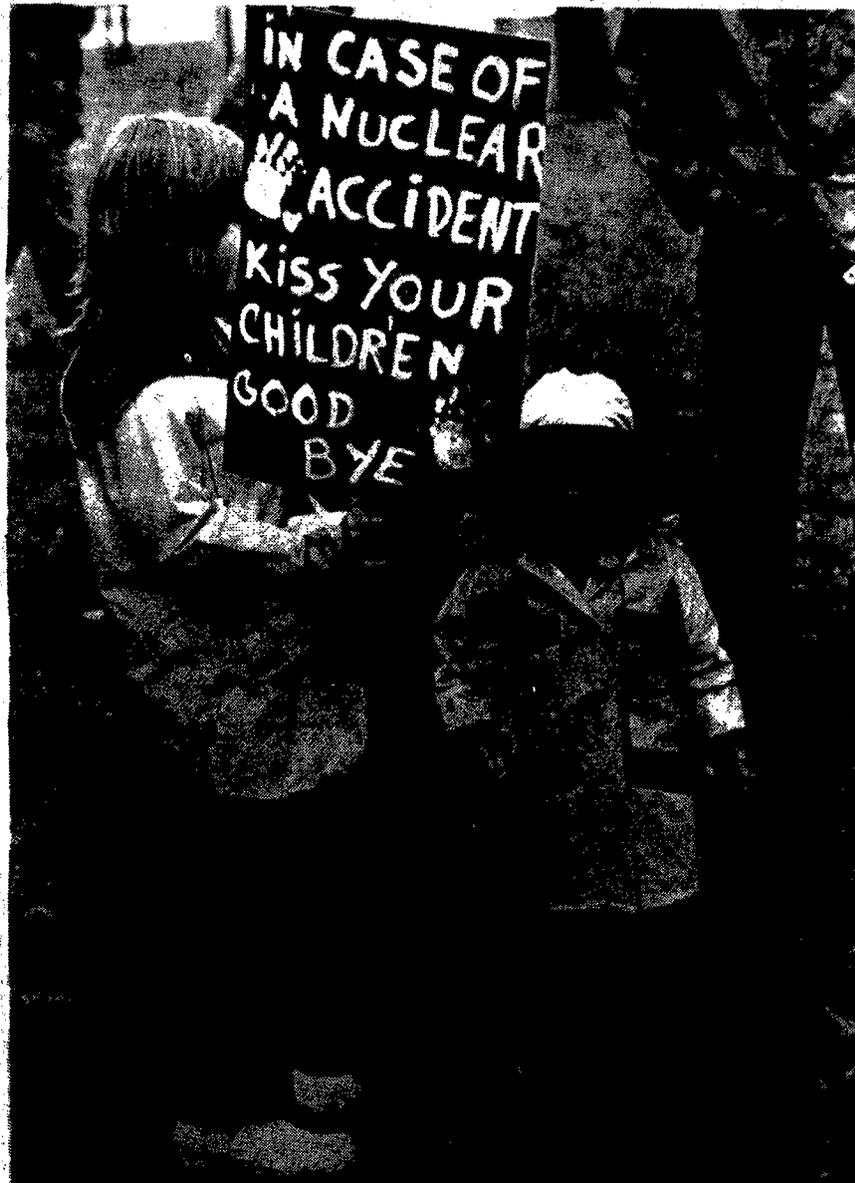
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