

What Women Aren't Told About Childbirth

By [Manda Aufochs Gillespie](#) and [Mariya Strauss](#), [AlterNet](#). Posted [October 20, 2007](#).

Even in this age of cybervoyeurism and hyperinformation, the act of having a baby remains one of the few bodily activities about which many people choose to remain blissfully ignorant. This might best be described as the "but it won't happen to me" phenomenon. Understandably, women hope, despite all they may learn otherwise, that pregnancy, childbirth and parenting will go easier for them -- *their* baby will sleep, *their* feet won't swell to the size of melons and, of course, *they* will have an uncomplicated -- sweaty, perhaps, but not seriously painful -- labor.

Like most myths, there are the people for whom the fiction is the reality, but they are the exception. Chances are your baby will cry at night; your feet will swell; and unless you are willing to research in depth, shop around for care providers and advocate stubbornly for what you want, you probably won't have the labor you expect. This isn't just a benign statement about how we never get what we expect: A new survey of mothers reveals some disturbing things about hospital maternity care that may make pregnant women want to take a closer look at their options.

The survey [Listening to Mothers II \(LM 2\)](#) was released in 2006 and reports on U.S. women's childbearing experiences. Conducted for [Childbirth Connection](#) by Harris Interactive in partnership with Lamaze International and Boston University School of Public Health, it is the first comprehensive survey of women's childbearing experiences. The survey population is representative of U.S. mothers 18 to 45 who gave birth to a single infant in a hospital, with 1,573 actual participants.

"The predominant picture that emerges from our data," the report states, "is of large segments of this population experiencing clearly inappropriate care."

The majority of women ended up attached to IVs, catheters and fetal monitors. They had their membranes artificially ruptured and were given epidurals. Most of these women had little understanding of the side effects of these interventions, including [cesarean](#) and medical inductions. The report also shows that though women understood that they had the right to refuse medical interventions, few did, and many received interventions, such as [episiotomies, without their consent](#).

[Just as troubling is what is not being done. A "very tiny minority" of women received all of the care practices](#) that promote natural birth. "With 4 million U.S. births annually, a single percentage point represents about 40,000 mothers and babies per year," the report authors say. Despite the relative health of women in the United States, many women are not getting the uncomplicated births they might expect.

But whose responsibility is it to make sure a baby's birth is a positive experience for the mother and her family? And what kind of birth do women want?

Achieving a more *natural* natural birth

Popular media outlets and advertisers would have women believe that labor and delivery happen in only one context: hospitals. When television shows, health magazines and films depict birth as a highly medicalized phenomenon that involves lots of screaming, a command to push and a baby before the next commercial break, it is no wonder that so few women in labor think to ask

for more information when they are offered medical interventions. Or that so few are educated about natural childbirth.

Juli Walter teaches childbirth education classes on Chicago's northwest side. "Most of my students have an idea when they come to class that they would like to have a natural childbirth," says Walter. "However, they don't really have an understanding of what they need to have a natural birth." Though some make an effort to learn about birth from other mothers or books, most pregnant women don't have a grasp of the details of childbirth -- things like the physical and emotional stages of labor, the anatomical changes their bodies are experiencing, or the amount of pain they are likely to experience in labor and delivery.

Even among the women who say they want a natural birth, the term "natural" doesn't always mean the same thing. Many people believe that labor and birth are a natural human process, engineered by evolution with such sensitivity that any intervention -- like administering anesthesia or drugs to speed labor -- could cause it to malfunction. Under this model, most births are attended by midwives who act as lifeguards -- well-trained birth professionals who will be constantly present and intervene only if serious complications arise. This type of assistance during a birth, says doula and [certified professional midwife \(CPM\)](#) Mary Doyle, is "more about collaborating and being an ally to a pregnant woman, honoring her choices and letting her be in control of her experience rather than dictating what is going to happen."

Following this model of care for labor and birth, a woman might have her baby at home or in a midwife-staffed birthing center, both with the ability to transfer to a nearby hospital. Women have all sorts of reasons for wanting an alternative to hospitals: "For some women, it's the intimacy of birth that makes them want a birth center or to give birth at home," says Gayle Riedmann, a [Certified Nurse-Midwife \(CNM\)](#) who runs a midwifery practice in Oak Park, Ill. She is a board member of the Health and Medicine Policy Research Group (HMPRG), a group of health professionals and researchers that advocates for health-related policy improvements across the state.

Others believe that all birth can be considered "natural" and that birth with epidural anesthesia and continuous [electronic fetal monitoring](#) is no less natural. A large percentage of women -- 76 percent of all women in the LM 2 survey -- wind up getting an epidural for pain during labor. Many doctors consider epidurals to be the standard of care for treating the pain of labor.

In a 2003 article on birth, the [American Family Physician](#) suggests childbirth classes as a good way to learn more about labor, natural childbirth, the benefits and risks of pain medications and alternative pain management techniques. These nondrug means of easing the pain of labor include walking, changing positions, taking showers or warm baths and using breathing exercises, hypnosis, relaxation and massage." The article also says that by hiring a [doula](#), a birth assistant who focuses on the laboring woman's needs, "you might be less likely to need pain medicines. You might also be less likely to have a cesarean delivery."

The LM 2 survey, however, shows that only 2 percent of women received all of these natural pain-relieving measures. Despite the fact that half of the interviewed women felt that birth should not be interfered with unless medically necessary, the vast majority received medical interventions. Many women reported experiencing pressure to have their labors induced, to accept an epidural and even to have a cesarean. A full 73 percent who had an episiotomy were not given a choice in this decision.

What are women not being told?

The World Health Organization recommends that the rate of cesarean births for any country not exceed 10 percent to 15 percent. The Centers for Disease Control and Prevention puts the U.S. rate at over twice that: [30.2 percent](#), and the LM 2 survey suggests this number is on the rise.

The United States is also one of the only wealthy countries where the maternal death rate is climbing. In 2004, the most recent year for which information was available, the maternal death rate in the United States jumped to [13 deaths per 100,000](#), according to the National Center for Health Statistics. This marks a significant increase from just four years earlier when it was 11 deaths per 100,000 births. Maternal death rates continue to be significantly higher for African-American and Hispanic women.

Among developed countries, the World Health Organization reports, 29 have better [infant mortality rates](#) than the United States, including Slovenia and Cuba, and 41 have better [maternal mortality rates](#).

Why are women in the United States more likely to die from childbirth than their peers in other industrialized countries? The rising rates of medical intervention and surgery in birth and their attendant risks are a big part of the answer.

Obstetricians tend to intervene in a normal birth

Walter says that women in her classes are routinely uninformed about the birth attendants they choose. "Most women just go with their OB who has been doing their pap smear for ten years and are like, 'Oh, I want to have a natural childbirth.'"

The LM 2 survey confirms Walter's perception: The majority of women surveyed never bothered to interview multiple providers or find a hospital with an approach to childbirth matching their own.

[Obstetricians](#) are surgeons with an expertise in female reproductive pathology. They often provide routine gynecological care, but when it comes to childbirth, their training has primarily prepared them to actively manage a high-risk birth or to intervene medically and surgically when something goes wrong during a birth. Though they may have attended hundreds or even thousands of births, few obstetricians have much experience with unmedicated births. Even fewer have attended out-of-hospital births.

Indeed, their professional association, the American College of Obstetricians and Gynecologists (ACOG), last year went so far as to issue a wholesale condemnation of out-of-hospital birth. They cited a lack of evidence to support the safety of birth outside hospitals, despite its undisputed [record](#) of safety in many other countries. In their Guidelines for Perinatal Care, fifth edition, published in 2002, ACOG states, "Although ACOG acknowledges a woman's right to make informed decisions regarding her delivery, ACOG does not support programs or individuals that advocate for or who provide out-of-hospital births."

One doctor who practices out-of-hospital birth anyway is Mayer Eisenstein, founder and medical director of Chicago's Homefirst Health Services. Homefirst provides doctors and midwives to attend births in homes. Though some people bristle at Eisenstein's hands-off approach to birth, he has been attending births in homes for over 30 years. With more than 14,000 deliveries, his practice maintains a cesarean section rate of less than 10 percent, an episiotomy rate of less than one percent (compared to nearly 35 percent nationally) and virtually no need for pain medications or I.V. fluids.

Many obstetricians have never witnessed a natural birth in its entirety, and today, Eisenstein says, a natural birth in a hospital is "almost nonexistent. It was more likely 25 years ago than today." People ask more questions when they buy a car or a house than they do when they choose the care provider and birth location that will be part of one of the most important experiences in the life of a family. All of the doctors are nice, he says, "but you're not hiring your doctor to like [him], you are hiring [him] to have the safest possible birth."

"For 20 years," says Eisenstein, "OBs have been saying you can't have your baby at home because it's too dangerous. The corollary would be, if you have it in a hospital, it would be safe."

"It's not true," he says. "Show me a study that shows it's safer to have a baby in a hospital. It's not evidence-based." Eisenstein says he feels that women are being led to believe that their low-risk pregnancies are likely to have better outcomes in the hospital and when something goes wrong, "they sue."

A cascade of interventions

Childbirth educators often talk about the "cascade" of medical interventions: the likelihood that once you receive one intervention, like [Pitocin](#), you are more likely to receive another intervention, like an epidural. Many women never question these interventions, though they frequently are linked to babies being born by cesarean section.

"In an unmedicated labor," Doyle says, "the body releases its own oxytocin, which stimulates contractions. The brain responds to the pain of these contractions by releasing endorphins. When synthesized oxytocin [aka Pitocin] is administered through an IV, contractions can come on quite suddenly, and these contractions are often longer, more intense and more consistent than the body's natural endorphins can keep up with." The intense pain of Pitocin-augmented labor often causes women who may have wanted an unmedicated birth to ask for or accept pain medication. Doyle has attended dozens of hospital births as a doula and has seen this phenomenon many times.

The Food and Drug Administration (FDA) has never approved Pitocin for the use of augmenting labor and it has been suggested now that mismanagement of Pitocin is the leading cause of liability suits and damage awards.

Continuous electronic fetal heart monitoring is another seemingly innocuous medical intervention that is linked to adverse outcomes. Even though it requires women to be strapped to a machine and therefore limits their mobility -- movement in labor is listed as one of the recommended comfort measures by Lamaze International -- it may seem that constant feedback on a baby's heart rate would reduce unnecessary interventions and surgical procedures. Yet, some studies have shown CEFM to be an ineffective indicator of fetal distress and one of the causes of the increase in cesareans.

"There is no scientific reason to do any of this stuff," says Eisenstein.

Cesareans lead to more cesareans

Once a woman has a primary cesarean, chances are she will have a cesarean for subsequent births. Fewer and fewer obstetrics and midwifery practices are willing to assist in a vaginal birth after cesarean, or [VBAC](#). The risks to both mother and baby from a potential uterine rupture

during labor are greater than they would be for a woman without a cesarean scar. This is part of the reason why the rate of cesareans is increasing nationally.

"A small proportion of mothers with a previous cesarean (11 percent) had VBAC, though quite a few would have liked to have had the choice but had providers or hospitals unwilling to support their vaginal births," according to LM 2. The vast majority of the women surveyed in the report supported the right of a woman to choose a VBAC. The [Healthcare Cost and Utilization Project \(HCUP\)](#), a 2000 study conducted by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, showed that the average hospital stay and total charges were over 40 percent higher for women with repeat cesareans than for women who manage to have a VBAC.

There are measures a woman having a cesarean can take to help her own chances of being able to have a VBAC. Evidence links a [fad](#) in obstetrics care -- the single layer uterine suture -- with an increase in incidents of subsequent problems like uterine rupture. Noted midwife and childbirth expert [Ina May Gaskin](#) advises in her book *Ina May's Guide to Childbirth* that a woman may be able to increase the likelihood of having a VBAC in the future and reduce the chance of other serious complications by requesting a double-layer suture: separate sutures for the uterine wall and for the skin and tissue covering the uterus.

The business of birth

With childbirth accounting for more than four million hospital stays annually and over \$33 billion dollars in aggregate charges in 2003, according to HCUP, babies are big business.

Many families choose -- out of convenience or out of financial necessity -- to go to a provider that is paid for by their health insurance company; it is often more affordable for a family to go to a doctor or nurse-midwife based in a hospital because healthcare providers generally will not cover home-based birth.

The irony is that, although patients may pay less out-of-pocket, hospital births cost a great deal more than births in birth centers or at home. Nationally, birth centers cost 30 percent to 50 percent of a hospital birth, and homebirths, which usually range from \$1,500 to \$4,000, cost a mere 10 percent to 30 percent of a hospital birth, on average. The difference in costs is partially due to how hospitals bill: "Each thing has a charge, each doctor. There are IV fees, different machines, even Kleenex fees. With a home birth you have a midwife fee and some supplies," says Ida Darragh, chair of the North American Registry of Midwives. Gayle Riedmann, the midwife from Oak Park, explains that birth centers, too, charge a single fee for the entire birth experience, adding, "A number of families who do not have health insurance and can't afford a hospital birth could use a birth center."

But here's a funny thing: Women without insurance are less likely to end up with cesareans, as are women with Medicaid, according to the HCUP study. Women with private insurance, the study says, have the highest cesarean rate.

Sue Thotz, a Chicago mother of two who had both children without medication in hospitals with midwives says, "I would have loved to birth at home." However, she explains this wasn't an option for her because, "Both births were insured with Medicaid, and the state doesn't exactly pay for homebirths." Of the national population surveyed in LM 2, 41 percent received Medicaid or similar government benefits for some of their care. Medicaid does cover the costs for CPMs in

nine states (including Arkansas, Arizona, California, Florida, New Hampshire, New Mexico, Oregon, South Carolina and Washington).

For most women, the fact that hospitals have virtually cornered the market on childbirth and maternity care means that birth itself can assume the form of a medical problem rather than a normal human process. And, since most mothers are giving birth in a hospital room surrounded by highly trained doctors and sophisticated medical instruments, a low-risk, unmedicated labor can rapidly convert into a complex surgical case.

Progress is being made nationally in providing birth options to women and their families. That progress, however, varies significantly from state to state. In [11 states](#) women are prohibited from having a homebirth-trained attendant (a CPM) at their birth or are forbidden homebirths altogether, and in 17 states there are no freestanding [birth centers](#) available to women.

In 2005, Virginia and Utah, and in 2006, Wisconsin passed regulatory legislation allowing CPMs to practice midwifery in their states. This year attention is on [Missouri](#), which has appealed to the state's Supreme Court to allow a new CPM law to remain standing, and on Illinois, which has passed [legislation](#) to legalize and establish freestanding birth centers and has a CPM licensure [law](#) pending. One by one, these states are helping families regain control of their own birth experiences -- and for some, that is preferable to the technological advancements hospitals offer.

"It's about choice," says Riedmann. Whether women choose hospital birth or evidence-based, skilled care outside a hospital, Riedmann sums up: "We have to respect women's choices."

Books for further reading on childbirth:

- [Ina May's Guide to Childbirth](#), by Ina May Gaskin, MA, CPM
- [Pushed: The painful truth about childbirth and modern maternity care](#), by Jennifer Block
- [The Think Woman's Guide to a Better Birth](#), by Henci Goer
- [Born in the USA: How a broken maternity system must be fixed to put women and children first](#), by Marsden Wagner, MD, MS

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