

ONE MATERNITY CARE IN CRISIS: WHERE ARE THE DOCTORS?

We do not see childbirth in many obstetric units now. What we see resembles childbirth as much as artificial insemination resembles sexual intercourse.

RONALD LAING, PSYCHIATRIST

Scene: A large hospital in Oregon. (This is a real-life story, as are the other stories in this book.)

Grabbing the telephone from the maternity ward secretary, the nurse blurts out, “Doctor, I have tried and tried to find the baby’s heart beat and then I got my charge nurse who tried and tried. We can’t get a fetal heart tone at all. We need you. Please come quick!”

The obstetrician replies, “Right. I’m leaving home now. I’ll be there in fifteen minutes, depending on traffic.” Click.

“But doctor, what should we do in the meantime?! Oh damn, he’s gone.”

The nurse rushes back to the labor room, where a woman lies moaning in pain, her face pale and sweaty, classic signs of shock. The nurse throws yet another blanket on and turns up the flow of oxygen in the mask over the woman’s face. Sadly, the nurse never consults another doctor, even though there is another obstetrician in the doctor’s lounge just down the hall, perhaps because, in general, nurses are discouraged from consulting another doctor if it is a private patient.

The woman’s obstetrician arrives twelve minutes later and quickly determines that there are indeed no fetal heart tones, and the woman is in shock. He realizes this is almost certainly a case of uterine rupture, a situation where the woman’s uterus, after an especially hard contraction, blows out like a tire. Uterine rupture is a known risk of Cytotec, the drug he has

used to induce the woman's labor. Now it is his face that turns pale as he finds himself confronted with the most feared of all birth catastrophes—one that could kill the woman and the baby. "Set up for emergency C-section," he shouts.

It takes twenty minutes to prepare the operating room for an emergency cesarean section, enlist the obstetrician in the lounge to assist, find the anesthesiologist, and get scrubbed. By the time the laboring woman's belly is finally cut open, the baby is floating free in the abdominal cavity, having escaped from the uterus through a large rip in the uterine wall.

Handing the deep blue, flaccid baby to the waiting neonatologist, the obstetrician orders, "Now let's cut out the damaged uterus."

The assisting obstetrician objects: "But we can repair it."

"No, it's quicker and easier to just remove it."

"But the husband is just outside the operating room door," replies the assisting obstetrician. "We should at least discuss it with him. Removing the uterus means they can't have another baby."

Perhaps because he doesn't want to face the husband, the obstetrician stops all discussion by turning back to the operating table and starting the removal of the damaged uterus.

Meanwhile, the neonatologist has determined that the baby is brain-dead, after nearly one hour without sufficient oxygen, due to the damaged uterus. The baby is rushed to the nearest neonatal intensive care unit, but dies twenty-four hours later. The mother is hemorrhaging from the ruptured uterus and receives a blood transfusion.

The outcomes of this story were tragic. A woman nearly died and a family was left with a dead baby and no possibility of having another baby in the future. Most tragic of all, it need never have happened.

We doctors have a fancy word for the appalling outcomes in a case like this: they are *iatrogenic*, or caused by the doctor. Cytotec is a popular drug among obstetricians who use it to induce labor, even though it has not been approved by the drug manufacturer, or by the FDA, for that purpose, and to date there is no scientific evidence showing that it is safe for that purpose.¹ On the contrary, in 1999, two years after this incident took place, studies proved conclusively that, while the risk of uterine rupture is higher than normal when Cytotec is given to "ripen the cervix" and induce labor, the risk of rupture is significantly greater still when it is given to a pregnant woman (like the woman in Oregon) who has had a cesarean section in the past and already has a weakness in the wall of her uterus at the scar.²

Here is another story. This one is about a recent “normal” birth in Northern California.

Ms. C chose Dr. E, an obstetrician, to care for her during her pregnancy and birth. She wanted to have a natural birth and his printed flyers advertised that he “believes pregnancy is not an illness,” “works toward making pregnancy a happy experience,” and “provides natural delivery methods.”

A week before Ms. C’s due date, Dr. E proposed that he induce labor with the powerful intravenous drug Pitocin. “Come to the hospital Friday at 7 A.M., and you’ll have a baby by dinnertime,” he said. What Dr. E did not add was “and I’ll be home for dinner.”

Inducing labor is medically indicated in rare cases, such as when the patient shows signs of preeclampsia (persistent, severe high blood pressure, edema or swelling due to an accumulation of fluid in the ankles, and protein in the urine)—or when the pregnancy is more than two weeks overdue and there are definite signs of fetal distress. In Ms. C’s case, there were no medical indications for inducing labor. Ms. C and her husband refused Dr. E’s offer and repeated their desire to let nature take its course.

A week later, Ms. C went into spontaneous labor and was admitted to the hospital at 11 P.M. Dr. E was informed by phone, but perhaps because it was 11 P.M., he did not come in to examine her. Over the phone he ordered the nurse to start Pitocin in the morning to “augment” or speed up the labor, though there was no medical reason to do so, as Ms. C’s labor had not slowed or stopped.

The next day, at 8:30 A.M., Dr. E visited Ms. C in the hospital for the first time, nine and a half hours after her admission and two hours after a nurse had started her on a Pitocin intravenous drip. During that time, no other doctor had seen Ms. C, and she was not told she was being given Pitocin.

At 8:40 A.M., and again at 8:43 A.M., there were signs of distress on the electronic fetal heart monitor. Ms. C’s chart indicates that her nurses were aware of these signs, but there is no indication that a doctor was called.

When drugs such as Pitocin are used to induce or augment labor, the pain of labor typically becomes much worse than normal.³ At 8:50 A.M., an anesthesiologist gave Ms. C an epidural block to relieve her pain. Administering an epidural block is a delicate procedure that involves putting a needle into the spinal cord just far enough for the tip to be in the spinal fluid and injecting an anesthetic. An epidural blocks all sensations below the injection site, leaving the lower half of the body without feeling.

Nurses notes indicate that at 8:55 A.M., Ms. C was completely dilated—a sign that it was time for her to push the baby out. However, Ms. C was

not told that birth was imminent. A nurse called Dr. E, and on the phone he gave the order, “tell her don’t push.” But the urge to push is spontaneous and out of the woman’s control—like trying not to vomit when the urge to vomit comes. For the next hour and forty-four minutes, the nurses tried to keep the baby from being born before the doctor arrived by urging Ms. C not to push and by pushing on the baby’s head to hold it back. Nurses’ notes indicate that Dr. E was called several times during this period and urged to come quickly. Nurses also gave Ms. C oxygen while she waited and told her it was for the baby, so we can assume that they were aware that holding the baby back was putting the baby at risk.

Ms. C had made it clear to Dr. E before she went into labor that she and her husband wanted a natural birth without surgical interventions, such as an episiotomy (the practice of cutting the vagina open supposedly to create more room for the baby). During her labor, Ms. C reinforced this point. She repeatedly told a nurse, “I do not want an episiotomy.” Dr. E rushed in at 10:39 A.M., more than two hours since his last visit, and gave her an episiotomy, for no apparent reason and without telling her what he was doing. Since she was numb from the waist down, she did not know he was cutting her. When she reminded him that she did not want an episiotomy, he said, “too late.” Dr. E then used a vacuum extractor to pull the baby out—again, for no apparent reason. (Dr. E claimed the reason was “fetal distress,” but there were no signs of fetal distress on the electronic monitor just before the birth.)

These two birth stories—one with a disastrous outcome, one not at all unusual—illustrate many of the egregious errors that go on in maternity care in the United States. The fundamental flaw: in America, we have highly trained surgeons called obstetricians regularly “attending” normal, or low-risk, births.

The United States and Canada are the only highly industrialized Western countries in the world where this is true.⁴ And Canada is rapidly converting to the system used in all other industrialized Western countries, including Australia, the Netherlands, Great Britain, all Scandinavian countries, Germany, and Ireland, and in many other countries, where more than 75 percent of all births are assisted by trained midwives. It is a midwife who provides prenatal care, a midwife who admits a woman to the hospital when labor begins (or goes to her home), a midwife who attends the labor, a midwife who assists at the birth, and a midwife who discharges the woman from the hospital. In these countries, obstetricians serve as specialists. They are essential members of the maternity care team, but they play a role only

in the 10 to 15 percent of cases where there are serious complications. Most women have babies without ever setting eyes on a doctor.

In the United States, the numbers are reversed. Obstetricians “attend” 90 percent of births and have a great deal of control, essentially a monopoly, over the maternity care system.⁵ Obstetricians are taught to view birth in a medical framework rather than to understand it as a natural process. In a medical model, pregnancy and birth are an illness that requires diagnosis and treatment. It is an obstetrician’s job to figure out what’s wrong (diagnosis) and do something about it (treatment)—even though, with childbirth, the right thing in most cases is to do nothing. To put it another way, having an obstetrical surgeon manage a normal birth is like having a pediatric surgeon babysit a normal two-year-old. Both will find medical solutions to normal situations—drugs to stimulate normal labor and narcotics for a fussy toddler. It’s a paradigm that doesn’t work.

This book will show that by embracing a medical model of birth and allowing obstetricians control of our maternity care, we Americans have accepted health care for women and babies that is not only below standard for wealthy countries but often amounts to neglect and abuse.

Let’s take a look at the stories above.

The birth certificate says that the obstetrician in Oregon “attended” the birth, but this is obviously a misstatement. It is a well-known fact among health care providers that in U.S. hospitals, “attending” obstetricians are almost never in attendance during a women’s labor, except for occasional drop-in visits, and are often not even in the hospital building.⁶ An episode of the award-winning TV series *ER* showed a woman in labor having convulsions. The emergency room doctor asks the nurse where the woman’s obstetrician is. The answer: “Across town in his office seeing patients.” If a pregnant woman in America signs on with an obstetrician thinking she will have him around during her labor, she is almost certainly in for a rude awakening.

Doctors are not inclined to discuss the consequences of their absence, but a recent study shows a 12 percent increase in neonatal mortality in babies born between 7 P.M. and midnight and a 16 percent increase in neonatal mortality for babies born between 1 A.M. and 6 A.M.. Researchers believe the increased deaths may be attributed to “the availability and quality of physicians, nurses and support personnel, as well as the accessibility of diagnostic tests and procedures.”⁷

A review of litigation cases in obstetrics and gynecology, commissioned by the prestigious Institute of Medicine in Washington, D.C., reported that

nearly two-thirds of labor and delivery injuries were caused by problems in medical management—that is, failure to adequately supervise or properly monitor.⁸ In the Oregon story, the obstetrician’s “failure to adequately supervise and monitor” meant that treatment was delayed during a crisis—a crisis that was brought on by the use of Cytotec, a drug that has not been sufficiently studied to have been proven safe. Does that amount to neglect? I think it *is* neglect on at least two levels. To begin with, the physician ignored the most basic principle of medical practice: *First, do no harm*. Second, the woman was given a powerful drug, then left to go through the second stage of labor (when the risk of developing complications increases) without a doctor’s continuous attendance but in the care of a nurse who was responsible for several women in labor and could check in only from time to time, as is usual in hospital maternity care,

It is no surprise that patients are neglected in a system where an obstetrician tries to be all things to all women. An American ob/gyn must be a primary care provider assisting normal, healthy pregnancies and births, a specialist in complications of pregnancy and birth, a counselor and family planning provider, a specialist in gynecological diseases, and a highly skilled surgeon. No other specialist anywhere in health care tries to maintain competence in so many areas. It is not humanly possible. Can an obstetrician do a major gynecological surgical procedure—such as a six-hour “pelvic clean-out” on a woman with extensive cancer—and then rush to his office and do a good job of quietly and patiently counseling a healthy pregnant woman about her sex life? Not likely.

In America, obstetricians’ plates are full to overflowing. There is no way they can do it all. And of all the things they try to do, the most difficult thing to fit into their busy schedules is normal childbirth, which lasts twelve hours (on average) and, as we all know, can happen night or day, seven days a week. As in these stories, the actual attendant for the majority of births in the United States is a labor and delivery (L&D) nurse with a telephone.

On average, L&D nurses receive only six weeks of on-the-job training in L&D nursing after completing their basic nursing training. They have no autonomy, and so if problems develop they can do nothing without a doctor’s orders. At the same time, L&D nurses are held responsible for accurately judging the moment of birth. If a nurse calls the doctor too soon, she may be accused of wasting the doctor’s time. If she calls the doctor too late and the doctor misses the birth, the doctor is equally unhappy. It is no wonder that the thirty thousand L&D nurses working in American hospitals are frustrated and exhausted.⁹

In most hospitals, L&D nurses are asked to closely monitor several women in labor simultaneously. Some level of neglect is inevitable in this situation. When you consider the fact that nurses work eight-hour shifts, the chance that a woman in labor will receive continuous, one-on-one care in the hospital is reduced to zero. This is distressing, since many studies have shown that one-on-one, continuous care by the same person throughout labor means a shorter labor, less pain, fewer complications, and better safety for mother and baby.¹⁰ Hospitals and health maintenance organizations (HMOs) say they don't have the money to provide continuous care to women giving birth. Yet somehow they *do* have the money to purchase and maintain expensive electronic fetal monitors and use them on all women—even those having low-risk births, without drugs to induce labor—despite the fact that there is no scientific evidence that routine electronic fetal monitoring improves birth outcomes.¹¹ Most hospitals believe in machines, not bodies and not human contact, and that is where the money goes.

Now let's look at Dr. E's management of Ms. C's birth in the second story. There are many reasons it is justified to call it abusive. First, Ms. C was given Pitocin for no apparent reason other than the doctor's convenience. Speeding up labor with Pitocin induction has been shown to carry the risk of overly rapid uterine contractions, which can mean insufficient oxygen for the baby and brain damage, as well as another serious risk, uterine rupture, which can be fatal for the woman and the baby.¹² Because the risks are severe, women receiving Pitocin must be closely monitored by the doctor. Dr. E ordered the drug without even examining Ms. C and didn't see her until after she'd been on it for two hours. Furthermore, it is likely that it was the Pitocin that caused Ms. C's labor pains to increase to a level where she needed an epidural, which carries its own risks—such as a sudden fall in blood pressure (depriving the baby of oxygen) as well as the risk to the woman of paralysis or death resulting from the anesthesia.¹³ The epidural also meant that Ms. C was robbed of the opportunity to feel the birth of her baby.

A second reason Dr. E's treatment of Ms. C must be considered abusive is that she was given an unnecessary episiotomy. Though it is a common procedure in the United States, episiotomy is actually called for only in rare cases, such as when the baby's head has come out but the shoulders are stuck. There are numerous scientific studies on the risks of episiotomy. One of the proven risks is long-term painful sexual intercourse, a condition which Ms. C has suffered from since this birth.¹⁴

Pulling the baby out with a vacuum extractor meant even more unnecessary risks, such as an increased risk of permanent urinary and fecal incontinence for Ms. C and an increased risk of brain hemorrhage for her baby. It is ironic that Dr. E said he used an extractor out of concern for the baby, when any difficulties the baby was having almost surely resulted from Dr. E's delaying the birth; if Dr. E had honored Ms. C's body, the birth would have happened an hour and a half earlier.¹⁵ With no other explanation available, it is fair to assume that the birth was delayed on Dr. E's orders, so he could rush in, catch the baby, and take the credit. Delaying birth for convenience is abusive. I first saw this happen as a medical student, and it is still common today, decades later. Based on his behavior, we can speculate that Dr. E was having a busy day (which explains why it took him so long to come when Ms. C was ready to give birth) and, though Ms. C and her baby waited for him, when he finally arrived he was in a hurry to get the birth over with.

Dr. E's management of the case is also abusive on a deeper level. When Dr. E gave Ms. C a drug without her knowledge, he violated her fundamental human right to be fully informed and to consent to any medical intervention prior to it being used on her body.¹⁶ Beyond not giving consent, Ms. C and her husband had made it clear to Dr. E that they did not want Pitocin when he offered it a week earlier. Beyond not giving consent to an episiotomy, Ms. C explicitly said she did not want one. Ms. C was not informed of the risks of using a vacuum extractor nor was she asked for her consent. However, given that she had made her desire for a natural birth very clear, it is safe to assume that if she had been asked she would have refused.

Dr. E blatantly rejected his patient's wish for a natural childbirth, and instead applied a surgical routine that by every standard was unnecessarily aggressive and interventionist. He turned what could have been a happy family event into a miserable surgical event. After the birth, Ms. C tried repeatedly—and unsuccessfully—to get information from Dr. E about why so many interventions were used. After her attempts to get information failed, Ms. C felt so betrayed and abused by Dr. E that she and her husband looked for a lawyer who could help them get some degree of closure. However, because the baby was apparently okay, and Ms. C suffered “only” from sexual problems and mental anguish, no lawyer was willing to take the case. Dr. E's damaging style of practice in this case must be called dishonest and unethical—and, sadly, as this book will show, it is quite common in the American maternity care system.

In a country where consumer rights are taken seriously and legally pro-

tected, it's hard to accept that a doctor like Dr. E can practice outrageous "false advertising" and expect to get away with it. But as we will see in the next chapter, obstetricians in the United States have great lobbying power, and they have fought hard to prevent regulations and laws that would hold them accountable for their actions. In forty-eight of the fifty states, doctors and hospitals are under no obligation to disclose maternity care statistics (rates for cesarean section, labor induction, episiotomy, and so on) to the public, which makes it very difficult for a woman to find out in advance how she is likely to be treated.¹⁷ When something goes wrong with her treatment, it is all but impossible to find out what happened or who is to blame—without filing a lawsuit. A severe lack of information is one of several reasons that in the United States obstetricians are sued more than any other medical specialist.¹⁸

The maternity care problems discussed in this book have profound costs for our society. Organized obstetrics groups such as the American College of Obstetricians and Gynecologists tell us that we have the "Cadillac" of maternity care. This is certainly true in one respect, since we pay much more per capita for maternity services than any other country in the world does. There are also good data showing that when obstetricians attend normal births, maternity services are far more expensive than when midwives attend normal births.¹⁹

But are we getting more bang for all those bucks? Are we number one in providing high-quality care? Hardly. Twenty-eight countries have lower maternal mortality rates (women dying around the time of birth) than we do,²⁰ and for more than twenty-five years, the number of women dying around the time of birth in the United States has been increasing.²¹ Every year, at least one thousand women—that is, three jumbo jets full of our sisters, daughters, and mothers—die around the time of childbirth, and at least half of those deaths could have been prevented. Forty-one countries have lower infant mortality rates (babies dying before their first birthday).²²

As you'll see in the coming chapters, our lousy track record is not caused by poor training. Obstetricians in the United States receive high-caliber education and training, and most also have good intentions. The problem lies not with individual doctors but with a system in which stretched-thin doctors have an unjustified monopoly and women and babies are left to pay the price.

It is important to note that in every country that has a lower maternal mortality rate than the United States—or a lower infant mortality rate—it is midwives, not obstetricians, who manage normal pregnancies and births.²³ In some of these countries a significant percentage of births take

place in homes and out-of-hospital birthing centers.²⁴ Studies that allow us to compare low-risk births attended by obstetricians and low-risk births attended by midwives show midwives to be safer, less expensive, and more likely to facilitate a satisfying experience for the mother and family.²⁵ In the United States, however, most obstetricians are vehemently opposed to midwives and have gone to great lengths to drive them out of business. Far beyond a mere territorial battle between two groups of health care professionals, the persecution of midwives in this country has taken on the fervor of an old-fashioned witch hunt. The result is fewer options for women. In many regions of the United States, a pregnant woman who wants the care of a midwife can't get it unless she's willing to go outside mainstream health care channels, and, in some areas, even risk being persecuted and/or prosecuted herself. See chapter 5.²⁶

Obstetricians have been telling women for decades that doctors are the only people who can provide them with a safe birth. Fortunately, as Abraham Lincoln said, you can't fool all of the people all of the time. More and more women are finding the courage not to believe everything obstetricians say. The percentage of births attended by midwives in the United States is increasing. Today, the number is 9 percent, up from 5 percent just ten years ago.²⁷

There are other encouraging developments as well. Health care in the United States is driven by the bottom line, and more and more HMOs are coming to realize that having midwives attend low-risk births saves money. Not only are midwives paid less than half what obstetricians are paid, but the number of risky, expensive, *unnecessary* interventions is cut in half as well.²⁸

Another hopeful sign: in 1999, a new edition of *Danforth's Obstetrics*, a popular textbook, devoted the entire first chapter to the value of practicing "evidence-based obstetrics and gynecology," that is, practicing medicine that comes as close as possible to what scientific studies show to be most beneficial and least risky for patients. The next year, a new edition of *Williams Obstetrics*, perhaps the most widely read obstetric textbook in the United States, followed suit. This emphasis on science was continued in the 2005 edition of *Williams*, leaving no doubt that obstetrics standard-bearers see it as the right direction for the field. As we will see in later chapters, today's actual obstetrics practices have a long way to go to meet the new standard, but a commitment in theory from the obstetrics establishment is certainly an important move in a positive direction.

Perhaps most promising of all, more women in the United States are coming to see the crisis in maternity care as a women's issue. It's about a

woman's rights to control what happens to her body and to have access to the best health care options available. For some time women have lobbied for the right to prevent—or end—an unwanted pregnancy, but a woman's right to control a wanted pregnancy and birth has received less attention. Now women's groups are taking on a wide range of issues related to maternity care, such as the need for transparency and accountability.

One example: after considerable struggle, women's groups in New York State got legislation passed requiring hospitals to report to the public on their maternity care practices, including the percentage of births by cesarean section. Several years after the law was passed, it became clear that few hospitals (if any) were complying with the law. An advocacy group called Choices in Childbirth brought the situation to light, which resulted in a public investigation. In their findings, New York City investigators expressed outrage at the high birth intervention rates in city hospitals and recommended that the law be amended to make failure to disclose required information a finable offense.²⁹

Of course, it is also important to remember that maternity care is not just a women's issue—the level of interest and commitment of fathers to the birth of their children, generally, could not be higher. I am frequently reminded of the importance of childbirth to the father when I hear once again that one of those most macho of men, a professional sports star, missed an important game because he rushed home to be with his wife during the birth of their child. It's just about the only excuse coaches and teams accept for an athlete's absence, and I have never once heard of a complaint.

In every country in the world where I have seen real progress in maternity care, it has been women's groups working together with midwives, nurses, doctors, doulas, scientists, journalists, lawyers, and politicians that made the difference. In the United States, the movement for demedicalizing and humanizing birth is gaining momentum. The Coalition for the Improvement of Maternity Services (CIMS) has taken the lead and now has more than fifty member organizations and more than ninety thousand individual members. Their mission: “to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs.”³⁰ These are the principles underlying this model:

- Normalcy: treat birth as a natural, healthy process.
- Empowerment: provide the birthing woman and her family with supportive, sensitive, and respectful care.

- **Autonomy:** enable women to make decisions based on accurate information and provide access to the full range of options for care.
- **First, do no harm:** avoid the routine use of tests, procedures, drugs, and restrictions.
- **Responsibility:** give evidence-based care solely for the needs and in the interests of mothers and infants.³¹

It's hard to find fault with these simple but profound concepts, yet they stand in sharp contrast with the reality millions of American women experience each year. If these principles were in place, neither of the real-life stories recounted in this chapter would have happened; women would not be faced with rates of cesarean section and drug induction of labor that are twice as high as science tells us are appropriate, using evidence-based care; and women and families would be free to have the childbirth of their choice.

This book is designed to further an understanding of problems in the maternity care system in the United States. In order to make changes, however, we need to begin envisioning solutions as well. I believe we can learn a lot by studying successful strategies developed in other countries and by looking at regions of the United States, such as New Mexico and Oregon, where important advances have been made. I will share my thoughts on best practices in obstetrics in chapter 8. The final chapter of the book will look at the movement for humanizing birth in the United States and suggest ways that all interested parties—from policy makers to pregnant women—can play an active role.