Chapter One ~ A Time Traveler

I am a time and place traveler who watched the 20th century history of childbirth unfold, decade by decade in the United States. I experienced it first-hand as a labor and delivery room nurse, childbearing woman and a professional midwife. As a naturally curious person, I have always had lots of questions about what I saw and so I studied resource that came into my hands on the history of maternity care, normal childbirth, and the practice of obstetrics through the ages. At 64 years of age, I have now dedicated the last stage of my professional life to telling what I describe as "**the last and most important *untold* story of the 20th century**". The best-kept secret in modern times is *how and why normal childbirth in a healthy population became the property of a surgical specialty and what the current costs and consequences of that are*.

The best place for me to start this story is where it started for me: the life−changing experiences I had as an 18 year-old nursing student in a racially segregated hospital in the South and then as graduate nurse working in the labor & delivery room of that same segregated hospital. I characterize this as the 'Dark Ages of the Deep South'. Due to an unequal, two-tiered system of medical apartheid, I got to closely observe and directly participate in two entirely different systems, side by side, in the same hospital, at the same time, with the same staff and the same type of patients but totally different management style and outcomes, different as day and night.

It was a naturally-occurring, one of a kind scientific study of two contrasting types of childbirth management. One was a profoundly interventionist model known as "knock'em out, drag'em out" obstetrics. This is style of obstetrical management was originally introduced by Doctors DeLee and Williams in 1910 and was still being used on our white maternity patients fifty years later, with only the most minor modifications. For our black mothers, the counterpoint to intense obstetrical intervention was a lazier-fair system, which was the classic physiological management provided by family-practice physicians and midwives in other parts of the world. In 1961, the difference between the extremes of childbirth under "knock'em out, drag'em out" obstetrics versus the traditional use of physiological methods all depended on whether the mother-to-be was black or white.

Childbirth in Black and White

In our segregated southern hospital, Caucasian mothers were admitted to the all-white labor ward on Five-North. Once they stepped thru the swinging double doors to the labor and delivery unit, they had to kiss their husbands good-by and were totally isolated from their family until after their baby was born and they had recovered from the anesthesia. On admission they were asked to take everything off (we meant *everything* -- eyeglasses, weddings rings and other jewelry, any dentures, braces, crutches, even an artificial limbs!) and put on a hospital gown. Then the mother's clothes and other belongings were placed in a brown paper bag and taken out to her husband in the waiting room. Fathers were not allowed in the labor and delivery area, so he was encouraged to go home with her clothes, wedding rings, eye glasses, etc, as he would not be able to see his wife until well after the baby was born. This was often 24 to 36 hours later.

Then newly admitted white patients were subjected to the traditional obstetrical 'prep'. Because poor women in the early 1900s sometimes had public lice, hospital policy in the 1960s still required our white labor patients to have their public hair lathered up and shaved off. Because

physicians in the early 1900s believed that infection following childbirth was sometimes the result of 'autogenesis' – that is, bacteria in the mother's vagina or intestines -- our labor patients were still being given a large soapsuds enema on admission. This was sometimes repeated every 12 hours if they weren't yet in good labor. Once the admission rituals were concluded, laboring women were routinely medicated with 3 grams of barbiturates -- a double dose of sleeping pills -- and put to bed.

As labor progressed they were injected every 2-3 hours with a narcotic mixture known as "twilight sleep" – large and frequently repeated doses of morphine or Demerol, a tranquilizer drug and scopolamine. Scopolamine is a potent hallucinogenic drug that causes short-term memory loss and permanent amnesia of events occurring under its influence. Women still felt the pain of uterine contractions, but under these powerful drugs some labor patients became temporarily psychotic and fought with the staff, often trying to bit or hit the labor room nurse. If left unattended, medicated patients often fell out of bed and could chip their teeth or brake an arm. To keep drugged women from getting hurt, the hospital required a nurse to stay right at the bedside through out the entire labor.

However the nurses were generally too busy to stay with each patient full time, so our white mothers were frequently put in four-point restraints, with arms and legs attached to the rails at the four corners of their bed. These were the same kind of heavy leather restraints used in the locked psychiatric wards of the hospital. They forced women to labor while lying flat on their back, a position that reduced blood flow to the uterus and placenta and made labor extremely painful. It also could cause fetal distress. Because labor was more painful when women were on lying on their back, the obstetricians in our area believed that labor was more effective when women were on their back, so they saw the use of leather restraints as an effective method for advancing the labor.

When the time came to give birth, our white mothers were moved by stretcher to an OR-type delivery room, put in stirrups, their pubic region scrubbed again and painted with Mercurochrome and then they were put to sleep with general anesthesia. Complications from obstetrical anesthesia was the third leading cause of maternal death in the late 1950s and early 1960s. After the mother was unconscious, a "generous" (!) episiotomy was done, and the delivery room nurse was instructed to provide "fundal pressure", using all her weight to push down as hard as possible on the top of the uterus. The idea was to mechanically press the baby down farther in the birth canal while the obstetrician used forceps to extract the baby. After the birth, the doctor would reach up inside the mother's uterus to remove the placenta and then finished up by suturing of the episiotomy wound.

For white babies that arrived under the standard obstetrical management, respiratory depression was the inevitable result of the narcotic drugs, anesthesia, anti-gravitational positions for pushing, the use of fundal pressure and forceps. The well-known effect of narcotic drugs and anesthesia was to obliterate the newborn's normal gag reflex (all general anesthesia has this effect). Since the early 1900s, when the use of general anesthesia for normal birth became the standard of care, the newborn's nose and throat were vigorously suctioned with a bulb syringe immediately at birth. This was repeated for any signs of choking or concern about the baby's ability to breathe. One of my jobs as a nurse in the all-white Five North delivery room was to resuscitate the many depressed babies who did not spontaneously breath at birth. As a

consequence of general anesthesia and/ or the use of obstetrical instruments, a significant number were never able to breathe on their own. For fundamentally healthy women with apparently normal pregnancies, the high mortality rate of the first half of the 20th century strongly reflected these iatrogenic factors.

For the obstetrician, routine care for white patients usually ended with the infamous "husband stitch". Double entente comments often accompanied this, as the doctor added a few extra perineal sutures when repairing the episiotomy incision, just to be sure the mother's vagina was tight as a virgin's again for her husband. Doctors explained that sometimes new fathers complained that: "*Ever since the baby was born, having sex with my wife is like walking into a warm room"*. Our doctors apparently felt responsible for preventing this type of marital dissatisfaction.

After finishing his handiwork and removing his surgical garb, the obstetrician walked over to the waiting room and announced to the waiting family that: "It's a boy!" or "It's a girl". He would congratulate the father with a handshake and bask briefly in the family's appreciation of his skill in safely delivering their baby, then send the relatives over to the nursery window for their first look at the newest arrival.

For the new mother, obstetrical management on Five North ended by being wheeled, still unconscious from the effects of anesthesia, to the recovery area. There she would lie on a stretcher for a couple more hours, retching and vomiting her way back to a dim consciousness before she finally asked: "What did I have?" This question was repeated by the mother (and answered by the nurse) many times before she was functionally conscious enough to realize the birth was over and keep the gender of her new baby fixed in her mind. Childbearing women were the least important person in this process and always the last to know about their own birth.

The Other Half of the Story

As a young student nurse, my head was still swimming from all this when I rotated off Five North to One South, the all-black ward. Oddly enough, the maternity care for black mothers was remarkably simple, straightforward, non-interventive, and in my uninitiated 18 year-old opinion, infinitely more humane. It met the mother's psychological needs and made right use of gravity. Biologically speaking, it was both safe and effective. When factoring in the negative effect of narcotics on the mother's labor and the respiratory depression it caused in newborns, the physiological care of black mothers-to-be was vastly safer than the medicalized version used on their Caucasian counterparts upstairs on Five North. This dramatic improvement between Five North and One South was a big relief. Being an agent for a process that was regularly harmful to mothers and babies had troubled me deeply.

All black patients -- medical, surgical, maternity, pediatric and elderly -- were admitted to One South, a segregated ward in the basement of our hospital. It was the oldest and most crowded wing in the sprawling hospital complex. Since it was originally built in the early 1900s, a huge institutional kitchen, an industrial-sized boiler room and the hospital laundry had been crowded in around the black wing, cutting off any view from the windows or access to open air. For black mothers-to-be, One South had no labor ward and no labor room nurses, so black labor patients were admitted to their postpartum beds in an old-fashioned four-bed ward. Under a policy of

benign neglect, there were no admission rituals, no sleeping pills, no drugs and no rules that said that black women had to stay in bed or labor on their backs.

In contrast to the restrictive protocols and tight control in the all-white labor ward on Five North, the labors of our black mothers were not accelerated with Pitocin or any other drugs. Nor were they given 'twilight sleep' (narcotics and scopolamine) or any other drugs for pain, because the two staff nurses were already responsible for 40-plus other patients. The skeleton crew assigned to One South had no time to labor-sit with drugged and combative women who were having hallucinations and trying to climb or fall out of bed. In addition to staffing limitations, a segregated society doesn't care what black women in labor wanted (or didn't want). Their opinions and needs didn't count. But no matter how reprehensible the motives, there were many unintended advantages to this system of purposeful neglect.

Left to fend for themselves, black labor patients moved around the big room, cheered on and cheered up by the older and more experienced women in the four-bed ward. This provided a useful source of encouragement and tips on how to cope with labor pain. Because they were undrugged and unencumbered, black mothers in labor were able to walk about freely, change positions at will or take themselves to the bathroom and sit on the toilet as the baby descended in the pelvis and they began to feel pushy. In particular, black mothers avoided lying down in bed, preferring to stand at the side of the bed and hold on to the bars as they swayed or squatted during contractions. As a naive student nurse, I remember asking one young black mom why she didn't lie down in the bed so she would "be more comfortable". She looked at me like I was a total idiot and in an irritated voice said: " …'cause it hurts too bad when you lay down!"

By an accident of race, these childbearing women were the beneficiaries of racial policies based in prejudice which co-incidentally shielded them from narcotics and artificial hormones to speed up labor or being forced to push in anti-gravitational positions. The labors of our black mothers were undisturbed and with rare exception, the physiological process unfolded as Mother Nature intended.

Eventually one of our black maternity patients would start to make deep-throated guttural noises -- the unmistakable sounds of pushing. One of the two floor nurses would grab a stretcher and help the mother lay down on it. Then we raced the stork through the hall to the elevator, hoping to make it to the 5th floor delivery room before the baby made its entrance. It was my frequent pleasure, as an impressionable student nurse, to 'catch' the precipitously born babies of our black mothers in the elevators that traversed the vertical and political distance between One South and Five North.

These normal births were managed physiologically by nurses, which is to say, the mother gave birth spontaneously, pushing her baby out under her own powers. And wonder of wonder, these babies immediately breathed on their own, since their mothers had not been given narcotics or anesthesia and no artificial, forcible or mechanical means were used to accelerate the labor or pull the baby out. In my experience none of these unmedicated babies need to be resuscitated. The mother had no painful episiotomy, no bleeding from a perineal incision, no forceps, no fundal pressure, no manual removal of the placenta, no bulb syringe thrust repeatedly down the baby's throat. These lucky babies were enthusiastically embraced by their undrugged and fully conscious new mothers, who beamed proudly and proclaimed in a confident voice: "*Look what I didß*"

By today's legal standards these black mothers were actually receiving substandard care. Racial prejudice and discrimination of the era had institutionalized what would be considered legally negligent treatment. Yet, they clearly were getting the better end of the deal. The nurses just talked these black mothers through the last couple of pushes and their babies just slipped out, with little fuss.

Had anyone in our hospital or our town or any researcher at the CDC been paying attention to this impromptu study of two opposing styles of birth management, the winner would clearly been the black mothers and babies on One South. They enjoyed the safer, physiologically managed labors and normal spontaneous births, while being protected from the routine indignities and painful interventions that were the norm five floors above. Our black labor patients were not subjected to the labor-retarding effects of social isolation or immobilized on their backs with four-point psychiatric restraints. They did not have their memory erased by scopolamine or their labor slowed down by narcotics. No routine use of forceps damaged the mother's pelvic floor or her baby's cranium. The new mother was not debilitated by the slowly healing episiotomy that made it hard to sit and difficult to care for a new baby. Their babies were not exposed to intrauterine narcotics and the resulting fetal distress, nor did they need to be resuscitated. This no doubt contributed to increased IQ points and, according to three Scandinavian studies, a reduced the incidence of drug addiction as young adults. It was clear to me that Mother Nature knew what she was doing. When we human helpers stayed respectfully out of her way, she did a darn fine job most of the time.

A Practical Application of our Black-White Study – an "N" of one

When expecting my first baby, I took my lesson in childbirth out of the book of segregated childbirth and its extreme contrasts. In an attempt to avoid the detrimental effects of routine obstetrical intervention, I asked my obstetrician if I could have the same kind of care that our black mothers received – no drugs, able to walk around during labor, no anesthesia, no episiotomy, no forceps, just a boring un-intervened with spontaneous birth. He smiled and kindly suggested that I just stay out of the hospital until the baby was ready to be born because "that's what hospitals are for -- drugs and anesthesia".

As a good and faithful nurse, I did exactly what my doctor said. I labored at home as long as possible, then left for the hospital with the hope of arriving just in time for a nice nurse-managed birth on a stretcher in that same elevator on the way up to the Five North delivery room. As luck would have it, I misjudged by a few block. While my husband drove the family car, I gave birth unattended in the back seat of our Renault to a lovely baby girl, just five blocks before we turned into the hospital driveway. It was the most surreal, most important moment in my life – the privilege of being the first person, after God, to welcome and hold my brand new baby daughter.

ER personnel wheeled the stretcher holding me and my newborn daughter, umbilical cord still firmly attached, placenta *in situ*, into the elevator and up to Five-North. It was 11:15 on a cold January night. At the same time, the 3-11 shift of L&D nurses were getting off duty, waiting in the hallway for the elevator. Like the many black moms that preceded me with spontaneous births in that same elevator, I held up my tiny newborn up as the door opened and said to my surprised colleagues: "Look what I just did!" This could be called the "elevator effect", but I shall always be

convinced that it is an immutable right of childbearing women to feel proud and happy and confident as a result of giving birth normally, under their own steam. On the way to my unlikely career in midwifery, that was the second milestone of a very long journey.

My L&D Time Warp – 1910 to 1976: Historically speaking, the policies and the process for providing obstetrical care to the white population of our hospital in the 1960s were *pristinely unchanged since 1910*, except for replacing the chipped white paint on the OR-style delivery table for shinny new chrome and (thank goodness!) substituting safer cyclopropane anesthesia for the much more dangerous chloroform and drip-ether. The last day work that I worked in the L&D unit in August of 1976, the obstetrical protocols of our hospital still routinely confined the mother to bed, medicated her with narcotics and scopolamine during labor and gave general anesthesia for delivery. Normal birth was still conducted as a surgical procedure that included episiotomy, forceps, manual removal of the placenta and sutures. It still ended with the mandatory separation of mother and baby and the unconscious mother was still the last to know what she had.

As a L&D nurse, I worked to rectify the tension between the two opposing models of maternity care used by every hospital in our part of the state for my entire career as a hospital employee. Despite my best efforts, I was utterly unable to make the 1910 version of obstetrics move even a tiny millimeter towards the physiological model that served our black moms so well. It finally became obvious that normal childbirth was permanently trapped on the wrong side of history, at least in Orlando, Florida. I threw in the towel and asked to be transferred to the ER, where I worked as emergency room nurse for the next several years. I too was traumatized by being the agent of the 'new' obstetrics to ever again be employed in a system that required me to do things I knew were harmful, humiliating and painful to mothers and babies. Eventually I joined a domestic Peace Corps project that did community development work in a very rural part of North Carolina.

Relieved of these onerous duties, I was able to study the problem without so much emotional angst and to get a far better perspective on the right use of obstetrical interventions and the best form of care for healthy women. My conclusion was simple: no healthy woman should never be forced to choose between an obstetrician and a midwife or between a hospital and a planned home birth in order to get physiologically-managed maternity care, nor should any mother-to-be have to give birth unattended in order to avoid unwanted obstetrical interventions or mandatory but medically-unjustified Cesarean delivery.

What I discovered was heartening, as it provided logical reasons for why and how the 'new' obstetrics came to be at odds with the fundamental purpose of maternity care, which is to make normal childbirth safer and more satisfactory for healthy mothers and their unborn/newborn babies. My study brought me insight, sympathy for obstetricians and empathy for the predicament the obstetrical professions finds itself in. I have identified a rational plan to address the immediate problems and a set of principles for restoring balance and rehabilitating our national maternity care policies. I am very hopeful and urge others to be encouraged.

One of the most simple and central issues is the current use of a surgical billing code for physiological childbirth. Normal birth needs its own specific billing code. A physiological code would once again acknowledge that childbirth is a continuum. Continuity of care by the primary birth attendant during active labor, the birth and the first hour or two of the new baby's life is a

biological imperative for safe childbirth. Fair compensation for birth attendants, via a physiologic billing code, is *an economic imperative* for birth attendants and institutions and the lynch pin to making the maternity care system work for everyone – mothers, babies, doctors, nurses, midwives and hospitals.