

A PRACTITIONER PERSPECTIVE

Traveling Through Time to Normal Birth

Faith Gibson, LM, CPM

My life as a professional time-traveler started as an 18-year-old student nurse in a segregated hospital in the Deep South of the United States. Because of a system of medical apartheid, I got to closely observe and participate in two entirely different systems, side by side in the same hospital, at the same time, same staff, same type of patients, but *totally different* management style and outcomes. This contrasting study of birth practices all depended on whether the mother was black or white.

One method was the type of “knock’em out, drag’em out” of obstetrics introduced in America by Doctor Williams in 1910 (1). More than a half a century later, laboring women in the all-white unit were still being isolated from their family and reduced to a semi-conscious state under the hallucinogenic-amnesic drug scopolamine and large, frequently repeated injections of Demerol. To keep hallucinating women from falling out of bed, we routinely used four-point leather restraints. Delivery included general anesthesia, routine episiotomy, and an extremely forceful and dangerous form of fundal pressure provided by labor and delivery nurses to facilitate the doctor’s use of forceps. Due to the depressive drugs, anesthesia, and traumatic delivery practices, we routinely resuscitated a large percentage of newborns; a significant number died or were permanently damaged. Hours after the birth, when the mother finally awoke from her anesthetic stupor, she would groggily ask the nurses: “What did I have?”

The model of care provided on the all-black ward in the basement of the hospital was a system we would now call physiological management. Labor for black

mothers was simple and undisturbed—no pain meds, no Pitocin, no labor ward rules, women “allowed” to get out of bed. Undrugged and unencumbered, our black patients were encouraged by the other women in their four-bed ward to keep calm, change positions often, and stay hydrated. They actively avoided lying down and much preferred to walk around or hold on to the foot of the bed and sway or squat during contractions. Taken together, these tactics met the mother’s psychological needs and made for the right use of gravity. With rare exceptions, the physiologic birth process unfolded as Nature intended.

At birth, these undrugged babies were embraced by their fully-conscious new mothers, who beamed proudly and proclaimed: “*Look what I did!*” Judging by the number of babies who did *not* need resuscitation at birth, the physiological method was vastly more successful than the obstetrical model used upstairs on our white patients. When I left the nursing profession in 1976, our newly integrated hospital had applied the policies of “knock’em out, drag’em out” obstetrics to all its patients, regardless of race. Black mothers and their babies were now receiving “equal treatment under the law.”

Between the extremes of obstetrical nursing in an era of segregation and scopolamine, and my life now as a midwife and activist, I studied the history of childbirth practices in the United States, paying particular attention to how and why we came to use this interventionist system on healthy women. Based on these insights, I’d like to offer my perspective on our aging 20th century maternity care system, keeping in mind that maternity care is ultimately judged by its results—the number of mothers and babies who graduate from its ministrations as healthy, or healthier, than when they started.

Last year was the hundredth anniversary of the uniquely American obstetrical system introduced by its founding fathers—Doctors De Lee and Williams. As a new surgical specialty, it officially defined care during labor as a highly medicalized form of crisis management

Faith Gibson is a former labor and delivery nurse and emergency room nurse, a professionally licensed midwife in private practice, and member of the California Medical Board’s Midwifery Advisory Council.

Address correspondence to Faith Gibson, LM, CPM, 3889 Middlefield Road, Palo Alto, California 94303, USA.

and instructed its practitioners to conduct normal birth as a surgical procedure. Originally, this development was a noble effort by the obstetrical profession to reduce the death rate from puerperal sepsis (childbed fever) in hospitalized maternity patients during a pre-antibiotic era. It represents *the most profound and far-reaching change in childbirth practices in the history of the human species*.

As professionals, we think childbirth practices in the United States have changed enormously since the bad old days that mandated Twilight Sleep, stirrups, forceps, and general anesthesia. But as a witness to both models, the only “change” in obstetrical thinking I noted was in the late 1970s and 1980s, when the traditional use of narcotics, scopolamine, and general anesthesia was exchanged for the use of epidural analgesia during labor as well as birth. Healthy women are still the patients of a surgical specialty; 90 percent (or more) of normal births are still conducted as a surgical procedure in an acute care medical institution.

A 1913 obstetrical textbook, *The Principles and Practice of Obstetrics* by Joseph De Lee (2) shows photos of childbearing women passively lying on their back, surrounded by scrub-gowned professionals in an intensely medical-surgical scene. If modern furniture and a flowered bedspread were imposed on this picture, we would see the same type of equipment sequestered behind the doors of blonde wooden cabinets in our present day labor-delivery-recovery rooms. While fathers are “allowed” to be present and labor and delivery nurses wear colorful scrub suits, the only thing different is that a very high rate of forceps deliveries under general anesthesia has been exchanged for a moderately high rate of cesarean deliveries under epidural analgesia. Worse yet, highly interventive obstetrical care for healthy women (accompanied by an ever-increasing cesarean section rate) has become the norm in many developed countries and is fast being imported to the poorest nations as part of for-profit hospital chains run by big corporations.

Normal hospital childbirth continues to be dominated by an air of anxiety; obstetrical practitioners relate to labor and birth as if it were a hand grenade with the pin pulled, afraid the slightest bump will cause it to explode. The woman is still a passive patient who looks to others to direct her actions and to grant permission or provide approval before she does anything on her own. The most important, *most central place in the whole scenario of normal childbirth is still the BED in the center of the room*, where we put the mother and expect her to stay.

Care for a normal childbirth is not merely abstaining from the routine use of interventions, but a proactive process for working with the biology of labor and birth. This includes physical and emotional support, patience with Nature, psychological privacy for the hormonally driven, quasi-sexual events of spontaneous labor, right use of

gravity, a self-directed mother-to-be who is allowed to control her own actions and the place, persons, and activities around her. Unfortunately, most of these supportive strategies are the opposite of standard obstetrical protocols, which are fundamentally at cross-purposes with the principles of physiological management. However, current obstetrical policies are a *perfect fit* for pharmaceutically based techniques for pain relief, induced and augmented labors, and assisted or operative deliveries, which are still the statistical norm in the United States.

This sad state of affairs is *not* the fault of the hospital staff, the attending physician, or the laboring woman—they are *all unwilling passengers on a train that left the station a century ago*, a system based on a hundred years of false assumptions that simply has never been reevaluated in relation to the 21st century. For the entire 20th century, the spirits of Doctors De Lee and Williams have been standing invisibly but powerfully at the door of every hospital’s L&D suite, endlessly whispering their 1910 mantra: “in ... **modern obstetrics** ... care furnished during **childbirth** is now considered ... to be a **surgical procedure**.”

This system is a trap for modern-day obstetricians, who have no choice but to adhere to its strict obstetrical model. The American College of Obstetricians and Gynecologists policies, hospital protocols by obstetrics department heads, and case law all functionally define *the use of physiological care by someone trained in the surgical specialty of obstetrics* to be a *substandard* and therefore *negligent* form of obstetrical care—that is, malpractice. Doctors cannot currently provide physiologically based care without making themselves vulnerable to litigation and risking their careers.

But it doesn’t have to stay this way. By reevaluating the historical reason behind these early 20th century decisions and identifying outdated rationales, it becomes possible to create a 21st century system that would provide a uniform standard of care for a healthy childbearing population (70%) and lead to an integrated, cooperative, multidisciplinary model based on “best practices.” There is no reason why we cannot develop an evidenced-based model for normal maternity care that is mutually acceptable to caregivers and patients alike and also a profitable part of the mainstream health care system. This model includes policy changes that benefit all stakeholders, such as a new, nonsurgical billing code allowing doctors to be reimbursed for physiologically based care and simple clinical practices that improve outcomes, are mother-baby-father friendly, and help reduce the cost of health care.

As a matter of national policy, the principles of physiological management for normal birth should be integrated with the best advances in obstetrical medicine to create a single, evidence-based standard for all healthy women with normal pregnancies. *Mastery in normal*

childbirth services means bringing about a good outcome without introducing any unnecessary harm or unproductive expense. In such an evidence-based model, the individual management of pregnancy and childbirth would be *determined by the health status of the childbearing woman and her unborn baby, in conjunction with the mother's stated preferences, rather than the occupational status of the care provider* (obstetrician, other physician, or midwife).

In practical and political terms, the cultural controversy over childbirth practices should not pit physicians and midwives against each other or pit obstetricians against family practice physicians. No healthy childbearing woman should ever be forced to choose between a midwife and a physician-obstetrician or between a home and hospital birth to have a physiologically managed normal birth.

We all embrace the life-saving contributions of modern medicine—surgery, antibiotics, blood products, obstetrics, neonatology, and more—in the context of complications and when requested by the childbearing woman. But in terms of expense, both human and economic, many of us question the continued use of an obstetrical model originally developed to treat high-risk pregnancies, complications, and emergencies as the standard for healthy childbearing women with normal pregnancies. This is not an “either-or” problem, because we can easily embrace both physiological *and* medically based methods of care as appropriate.

To move beyond the historical theories of 1910, childbirth practices that are no longer beneficial must be corrected or replaced. This action would provide a new foundation for maternity care for healthy women that is separate from the surgical specialty of obstetrics and acknowledge the physiological model of care for healthy

women to be a science-based standard in its own right. In a healthy population, normal labor and birth is a single contiguous biological process.

As a distinct and independent standard, the health care system must recognize the legal and practical difference between physiological management (a nonsurgical primary-care practice) and obstetrics (a surgical specialty). Practitioners of each discipline must commit to cooperate and collaborate in achieving the mutual goals of safety and satisfaction for new mothers and babies. The result would be a uniform standard of care for a healthy childbearing population in which the individual management of pregnancy and childbirth is determined by the health status of the childbearing woman and her unborn baby, in conjunction with the mother's stated preferences, rather than the occupational status of the care provider. This model of maternity care would be cost effective and work for all stakeholders as well as the mainstream health care system.

Unless the mother asks for our help or there is a genuine medical need, it is our duty as professionals to stand to the side, and while never taking our eyes off the ball, let the physiology unfold normally, at its own pace and in its own way. That is the art and science of modern care for a healthy childbearing population.

References

1. Williams HS. *Twilight Sleep: A Simple Account of New Discoveries in Painless Childbirth*. New York & London: Harper & Brothers Publishers, 1914. Accessed April 1, 2011. Excerpts available at: http://healthcare2point0.com/JWWilliamsQuotes_OBOSversion_Aug2010.htm.
2. De Lee JB. *The Principles and Practice of Obstetrics*. Philadelphia & London: W.B. Saunders, 1913.