

# Why This Book? The Failure of Obstetric Management

It has been a long journey since the early 1990s when I began writing *Obstetric Myths Versus Research Realities*, my first attempt to illuminate the gap between conventional obstetric management and the care model supported by the research.<sup>11</sup> At the time, I was teaching Lamaze classes and attending births as a doula. I essentially wrote the book I wanted to have on my bookshelf but which did not exist. It turned out I was not the only one who wanted a book that provided an evidence basis for a different model of care: *Obstetric Myths* became a modest hit in the birth community. Subsequently, I gave up teaching Lamaze and attending births as a doula to concentrate on writing and speaking about what the research establishes as safe, effective, satisfying care. I learned much about this, helped greatly by the burgeoning power of information technology and by becoming part of a community of like-minded people interested in the evidence underpinning maternity care. This book will take advantage of all I have learned in the 17 years since the publication of *Obstetric Myths*.

I hadn't gotten very far along with this book before I realized that it would benefit greatly from a co-author, and I knew just the person: Amy Romano, an academically inclined nurse-midwife experienced with birth in and outside of the hospital, whose knowledge and expertise worked synergistically with my own. We shared an affinity for physiologic care and the application of logic to maternity care research, but while I brought historical perspective and the insights of a system outsider, Amy brought her clinical knowledge and a public health systems perspective. She also had just given birth to her second child when we started this project, so she brought the maternity care user perspective as well. The collaboration has been a rich one, resulting in a much better book than I could have written alone.

*Optimal Care* may be new, but my viewpoint has not changed. What I said in the introduction to *Obstetric Myths* holds true, this time for both of us:

Because I have biases (although I hope I am not prejudiced), I think you should know more specifically what those biases are. I believe we have a maternity care system whose unconscious principles and resultant conscious practices fail those who should be its primary beneficiaries.

I am . . . opposed to the routine use of intervention. I have attended labors in which the judicious use of technology probably saved the baby and, even in a case or two, possibly the mother, but the key word is judicious. I believe the injudicious use of technology is doing considerable physical and psychological harm to mothers and babies....

Here is what I think defines good care. Good doctors (and midwives):

- believe childbearing to be a fundamentally healthy and normal part of a woman's psychosexual life;
- treat women holistically, taking into consideration their thoughts, feelings, concerns, and priorities;
- respect the right of women to make informed decisions for themselves and their babies;
- respect labor as an experience with its own lessons and rewards;
- offer supportive rather than interventive care;
- evaluate individually and do not treat by rule;
- start small when intervention becomes necessary;
- keep abreast of the medical literature. (p. 3-4)

This book uses the obstetric research to show that care based on these principles will produce optimal mental and physical health and wellbeing in mothers and babies. It also offers an explanation for the gap—we may even say the chasm—between optimal care and current practice despite most practitioners'—although, unfortunately, not all—having the best interests of the women and babies under their care at heart. We hope that this knowledge will assist those of you working to reform our maternity care system, because in the end it does not matter what is in the care provider's heart; the harm done to mothers and babies is the same.

### **TWO CONTRASTING MODELS: BY THEIR FRUITS YE SHALL KNOW THEM**

Two oppositional philosophies underlie the competing concepts of good maternity care. Medical management practitioners start from the premise that pregnancy and birth are intrinsically difficult and potentially dangerous processes that, when left to occur naturally, frequently result in poor outcomes. It follows that childbearing women require intensive monitoring for complications and aggressive intervention to prevent and treat them in order to achieve the best outcomes. Proponents of physiologic care hold that pregnancy and childbirth are healthy, normal experiences for the vast majority of women and their babies. The best outcomes will be achieved when caregivers promote and facilitate the natural process and reserve medical intervention for times when these measures prove inadequate.

Important consequences flow from the differences between these philosophies. The first is the definition of "good outcomes," a difference that drives much of how the two models organize maternity care. The medical management model

defines success as a live mother and a live baby in reasonably good physical condition at the time the patient is discharged from the provider's care. Care is therefore structured to prevent and, when prevention fails, manage serious problems that may result in death or serious short-term morbidity.

In contrast, the physiologic care model strives for optimal wellbeing of the mother and baby within the context of the family and broader society. This encompasses the absence of morbidity and mortality but also takes into account that the childbirth experience can potentially affect—for good or ill—long-term physical and psychological health, breastfeeding, mother-infant attachment, and parenting.

### **The Provenance of “Optimal Care”**

Our use of *optimal care* derives from the American College of Nurse-Midwives' concept of optimality in maternity care. Midwifery researchers developed an instrument, the Optimality Index-US, that focuses on measuring positive outcomes, factoring the care process into that evaluation. Optimality is defined as the “maximal perinatal outcome with minimal intervention placed against the dynamic context of the woman's social, medical, and obstetric history” (p. 766)<sup>14</sup>—in other words, the least use of medical intervention that will produce the best outcomes given the individual woman's case. As this describes the goals for care that we espouse, we adopted it.

*Physiologic care* is the use of supportive care practices and low-technology techniques that facilitate the normal biological process of childbirth. It comprises optimal care for healthy women experiencing uncomplicated labor. Optimal care for women with complicated pregnancies or complex medical needs may involve more intensive monitoring and significant medical or surgical intervention; however, the *physiologic care model* dictates using physiologic approaches and engaging the woman as an active participant to the extent safely possible.

The second consequence is the difference in strategies used to achieve good outcomes. To manage complications and prevent disasters, medical management practitioners have adopted the maximin approach from game theory and military strategy.<sup>4</sup> Maximin (also known as minimax) strategies are designed to *minimize* the *maximum* potential losses. Accordingly, tests and procedures that were intended to prevent, diagnose, or treat uncommon complications are used frequently or routinely, although only a small minority stands to benefit from their use. For example, hospital policies prohibit eating and drinking during labor in hopes of

preventing the 1 in 3 million chance of dying of aspiration pneumonia (see chapter 11); care providers routinely induce labor at 41 weeks or even sooner to avert the less than 1 in 1000 chance that a healthy woman will experience a stillbirth late in pregnancy (see chapter 7); and women who have had previous cesarean surgery are forced to have repeat cesareans to avert a 1 in 3300 chance of a perinatal death resulting from uterine scar rupture (see chapter 6).

The physiologic care model, in contrast, is organized to maximize positive effects and minimize negative effects on the broader set of outcomes. Physiologic care focuses on preventing problems from arising in the first place by maintaining health and wellbeing and promoting optimal physical and psychological adaptation to pregnancy, labor, birth, and breastfeeding. Optimal outcomes are achieved by reserving machines and medicines for the times when normal physiology and preventive approaches are not sufficient.

These two fundamentally different approaches give rise to distinct perceptions of iatrogenic harm (injury or illness resulting from medical treatments and procedures). To continue the military metaphor, iatrogenic harms are the “collateral damage” of maximin obstetrics, unfortunate but supposedly unavoidable side effects of the tactics used to safeguard the mother and infant. In obstetrics, iatrogenic harms may come in the form of increased pain and suffering, more complicated labor, or fetal or newborn compromise, for example. In the long term, iatrogenic harms may manifest as chronic health problems (pelvic pain, gastrointestinal complaints), poor psychological outcomes (posttraumatic distress symptoms, depression, anxiety, or attachment disorders), or adverse effects on future reproduction (infertility, complications in future pregnancies).

To make matters worse, the medical management model tends to rely on more intervention to correct these problems. For instance, when high-dose oxytocin infusion leads to nonreassuring fetal heart rate, the medical management model calls for IV fluid boluses, internal fetal monitoring, and, ultimately, cesarean surgery. In contrast, clinicians working within the physiologic care model would minimize use of oxytocin because of the potential for fetal adverse effects, opting instead to use patience and supportive techniques to promote labor progress. Should oxytocin become necessary, they would administer physiologic doses and avoid co-interventions that might contribute to fetal intolerance of labor such as supine positioning or amniotomy. Physiologic care proponents argue, and this book will demonstrate, that collateral damage can be prevented with a wellness-oriented, low-technology approach to care without compromising outcomes.

The two models also diverge in whose needs and concerns take precedence. The medical model centers around the doctor and institutional staff. Their comfort and convenience are paramount and care is structured to meet their needs. The woman, cast in the role of “patient,” is expected to comply with policies, routines, and preferences, however disruptive or uncongenial she finds them, without complaint. Taking

an authoritarian approach, the doctor makes all decisions, speaking as well for the baby's interests, which may be perceived as antithetical to those of its mother. The woman is expected to submit to her provider's authority, forfeiting her autonomy, bodily integrity, and physical and mental health when her care providers consider it necessary. The doctor makes decisions according to what he or she deems acceptable risks, a determination often based on self-interested motivations such as protection from malpractice suits or time management. For example, the clinician who advises induction at 41 weeks to avert the 1 in 1000 chance of stillbirth often has no problem with the liberal use of cesarean surgery, which increases the risk of neonatal death by the same amount and confers excess risk of pregnancy loss and perinatal death in future pregnancies. (See chapter 5.)

In marked contrast, the physiologic care model puts the woman at the center. Mother and baby form a single, inextricable unit; what is good for the mother becomes, by definition, good for the baby. The care provider's role is to provide the environment, resources, advice, unobtrusive monitoring, and encouragement that will promote the woman's ability to cope with and overcome the challenges intrinsic to labor and birth, thereby facilitating the natural process. Decision-making is collaborative. The woman articulates her needs and concerns and freely exercises her right to informed consent *and* refusal for both herself and her baby after consultation with her care providers and others. In labor and after birth, the care and setting are arranged to accommodate the needs of the woman and her baby. For example, in addition to pharmacologic means of dealing with labor pain, the woman has access to a full range of comfort measures. According to her inner dictates, she may move about, choose various positions, vocalize, drink to thirst, eat to hunger, and decide when and how to push. When the rare complication occurs, the woman actively participates in resolving it. Most importantly, when she or her baby requires medical intervention, they continue to receive sensitive, respectful, high-touch care.

The two models of care differ as well in their consequences for the organization of the maternity care system. The medical management model maintains that safe care requires proximity to specialized technology and those trained to use it. It follows that the gold standard for safety is universal hospitalization of birthing women under the supervision of obstetricians and preferably in a tertiary care center (a hospital with a neonatal intensive care unit and maternal-fetal medicine and neonatology specialists). Proponents of physiologic care, on the other hand, point to evidence that the mere presence of such technology leads to its overuse and therefore to preventable iatrogenic harm without improving outcomes. (See chapters 20 and 21.) Healthy laboring women, it follows, will be better off in settings that lack the accoutrements of high-tech surgical obstetrics. On these grounds, the World Health Organization recommends that healthy women at low risk of complications in labor should be attended by someone with midwifery

(note: not surgical) skills and that care should be provided at the “most peripheral level where birth is feasible and safe and where the woman feels safe and confident” (p. 37).<sup>22</sup> A maternity care system structured on these principles would provide midwives and birth settings stocked with basic equipment and medicines in every community, with efficient linkages to more sophisticated levels of care when it becomes necessary.

Finally, the two models of care diverge in the meaning assigned to birth within the larger family and societal context. By organizing care to prevent and treat pathology, the medical management model disregards the fact that, ultimately, birth is a transition to parenthood. The medical approach devalues both the importance of supportive care in assisting women to make this transition and the price paid by mothers, babies, families, and society at large when that transition is problematic. It also disregards how a model instilling the impression that women’s bodies are incompetent to birth their children without expert help erodes a woman’s confidence in her ability to care for her child. Attachment and breastfeeding are seen as niceties to be attended to after the mother and baby are “out of harm’s way,” with no recognition that physiologic care achieves all three goals. For example, uninterrupted skin-to-skin contact in the hours after birth promotes the optimal physical transition for both mother and baby while also enhancing breastfeeding and parenting outcomes, beneficial effects that persist well into infancy. (See chapter 17.)

The choice of model is critical because its assumptions and principles dictate care. Models should live or die depending on how well their application achieves their own goals. How has near universal implementation of the medical management model fared in this respect?

### **OBSTETRIC MANAGEMENT: BROKEN PROMISES**

Since the publication of *Obstetric Myths*, with one exception, medical intervention rates have soared, and even that one exception, an episiotomy rate that has fallen from one in two women giving birth vaginally to one in four, could be one-tenth of what it is.<sup>8, 16</sup> The cesarean surgery rate, which approached one in four women before falling back to one in five, now has reached one in three, and *is rising in every subgroup of childbearing women*.<sup>13</sup> Far too few in the mainstream obstetric community have a problem with that. Elective primary cesarean surgery, which I treated as an example of a fringe extreme in obstetric thinking in *Obstetric Myths*, is now termed “maternal request cesarean” and presented as a reasonable alternative to vaginal birth. Vaginal birth after cesarean (VBAC), which slowly gained ground as the 1990s progressed, has nearly disappeared. Fewer than 1 in 10 women with a prior cesarean will ever give birth vaginally again, although 3 out of 4 or more could have a vaginal birth if they were allowed to try.<sup>12</sup> According to U.S. government statistics, the induction rate in 2008 was 23%, a 138% change since 1990, but this is among all women, including women having planned cesareans.<sup>18</sup>

An analysis of deliveries at 19 U.S. hospitals between 2002 and 2008 reported that nearly 1 in 2 women (44%) planning vaginal birth were induced.<sup>24</sup> According to Listening to Mothers II, a U.S. national survey of women giving birth in 2005, only 2% of women experienced all of the care practices that, according to Lamaze International and based on World Health Organization recommendations, promote normal birth.<sup>8</sup>

Increased use of tests, procedures, drugs, and restrictions has not paid off in healthier mothers and babies. We have seen minimal improvements recently in the preterm birth rate, but it is still higher than it was throughout the 1980s and 90s.<sup>13</sup> The maternal mortality rate is rising, and experts believe that for every maternal death there are at least 50 “near misses” not counted in the statistics.<sup>2</sup> While the physical casualties mount, what is not even on the radar screen is the psychological damage inflicted by a system that systematically undermines women’s self-confidence and traumatizes many. In the first year after birth, two out of three women participating in Listening to Mothers II reported depressive symptoms at the time of the survey.<sup>8</sup> In a follow-up survey a full 9% appeared to meet all of the diagnostic criteria for childbirth-related posttraumatic stress disorder.<sup>9</sup> Nearly one in five (18%) had consulted a healthcare or mental health professional about their emotional wellbeing and nearly one in three (30%) reported that their emotional wellbeing interfered with their ability to care for their babies. Five percent of mothers had considered suicide. It sometimes seems that we could hardly do better at sabotaging maternal-child health and wellbeing if that were the goal. By all measurements, the medical model has failed dismally. In an ideal world, replacing it with a model that works would be easy, but in the real world this is far from the case.

### **OBSTACLES TO CHANGE: THE USUAL AND NOT-SO-USUAL SUSPECTS**

Although the medical management model prevails in the United States and many other industrialized nations, every group that has ever set out to design a healthy maternity care system or to define quality maternity care has articulated the principles and practices of the physiologic care model.<sup>5, 7, 10, 17, 20, 22</sup> The wheel has been reinvented repeatedly, yet somehow we cannot get it rolling. The obvious question then becomes, Why not? A closer look at the forces that maintain the status quo should prove useful to anyone trying to implement reforms.

Chief among disincentives for change are core medical management model beliefs, starting with the belief that intensive use of tests, procedures, and medication protects doctors and hospitals from liability by showing that everything possible has been done to prevent a poor outcome. In reality, a 2009 survey of ACOG’s members found that 91% of respondents had been sued,<sup>15</sup> which means that this approach *does not work*, but medical management model beliefs have blinded many to this fact, as well as the fact that obstetricians helped create the liability problem in the first place by implying that intervention-intensive management

would avert bad outcomes. As Marsden Wagner (2006) has written, “If you play God, you will be blamed for natural disasters” (p. 162).<sup>21</sup>

The medical management model also reduces anxiety by conferring an illusory sense of greater control over outcomes. Unlike the natural process, where, in medical model thinking, “anything can happen,” medical management makes labor and delivery predictable, including its complications, and when complications occur, everybody knows what to do, up to and including the aces in the hole, cesarean surgery and hysterectomy, literally the ultimate rescue operations for baby and mother. With this mindset, a high-tech setting becomes essential.

Other barriers arise from perverse economic incentives. The ability to start and speed up labor artificially and to terminate it surgically enables obstetric care providers and facilities to control the timing and duration of labor.<sup>3</sup> This makes staffing and resource needs predictable, which reduces cost and allows practitioners more efficient time-management and convenient work hours. High epidural rates permit the extremely high costs of maintaining an anesthesia service to be amortized over the greatest number of patients, while nonpharmacologic measures and supportive care are not reimbursed. High-tech management increases hospital billing opportunities by increasing the use of equipment, drugs, lab tests, etc. Neonatal intensive care units (NICUs) can be profit centers, but they must be staffed at all times and overhead is large,<sup>1</sup> which means they require high occupancy rates. NICUs also eliminate the need to transfer high-risk patients out of the institution, thus losing the revenues they generate. Cesarean surgery increases postpartum stay and readmission rates, and each additional day of hospitalization enhances revenues. Indeed, from the perspective of all interested parties—other than the mother and the baby—the ideal birth is a scheduled c-section.

A final obstacle to change is one we would not have predicted when *Obstetric Myths Versus Research Realities* was published: the era of evidence-based practice. We, along with other advocates for maternity care reform, expected that evidence-based medicine would be the antidote to opinion-based practice. Science, not what a Lancet editorial scathingly called “GOBSAT”—Good Old Boys Sat at Table—would dictate care practices.<sup>19</sup> In the early 1990s it looked as if that dream might come true. The American College of Obstetricians and Gynecologists (ACOG) began issuing practice guidelines that were aligned with the research, and the mounting cesarean rate reversed course while the VBAC rate rose, but the revolution was short-lived. Despite growing evidence against the routine or frequent use of virtually all obstetric procedures, restrictions, tests, and medications, their use continued unchecked or even grew. Some harmful and ineffective practices have persisted because many clinicians do not keep abreast of the research or simply do not follow it, but as pressure mounted to practice obstetrics according to the evidence, studies began appearing that seemed to support intervention-intensive birth. A closer look, though, reveals that they are no more than what Phil Hall, a



Canadian obstetrician, as witty as he was wise, called “decision-based evidence making.” As our next chapter will show, the precepts of evidence-based medicine render it vulnerable to subversion, both unintentional and intentional. In fact, as we will see, in many instances ersatz evidence has been used to give credibility to the medical management model. The body of research is now riddled with these faux studies, and because of the misplaced belief in the inerrancy of the process that produces them, they have been accepted into the obstetric canon, included in systematic reviews, and used to justify practice.

By now you may be thinking that the situation is hopeless; resistance is futile. It is not, but those wanting to reform maternity care need a solid foundation in what the obstetric evidence does, does not, or only seems to support, as well as an understanding of the impediments to change and how they are influencing the system. We propose to provide you with that. Along the way, we will help hone your skills at recognizing internal inconsistencies in the medical management model, identifying its unconscious assumptions, and exposing its faulty logic. You should emerge much better equipped to defend a model of care that is safe, effective, and satisfying and to avoid being misled or co-opted.

Despite the deck being stacked against physiologic care, we must not give up. The stakes are too high. The financial costs of medical management to society are enormous—just reducing the cesarean surgery rate to the World Health Organization recommended 15% would save \$3.4 billion dollars annually.<sup>6,13,23</sup> (See chapter 3 for analysis.) The human cost is also enormous. As a result of overzealous use of technology in labor and birth, millions of women and babies have suffered, and all too many have died. Without a doubt, being a change-maker is likely to be frustrating and difficult, but when the health and wellbeing of childbearing women, babies, and society is at stake, no effort is too great, no accomplishment that forwards that goal too small.

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