

ROUNDTABLE DISCUSSION: PART 2

Why Do Women Go Along with This Stuff?

PREFACE: *Normal childbirth has become jeopardized by inexorably rising interventions around the world. In many countries and settings, cesarean surgery, labor induction, and epidural analgesia continue to increase beyond all precedent, and without convincing evidence that these actions result in improved outcomes (1,2). Use of electronic fetal monitoring is endemic, despite evidence of its ineffectiveness and consequences for most parturients (1,3); ultrasound examinations are too often done unnecessarily, redundantly, or for frivolous rather than indicated reasons (4); episiotomies are still routine in many settings despite clear evidence that this surgery results in more harm than good (5); and medical procedures, unphysiological positions, pubic shaving and enemas, intravenous lines, enforced fasting, drugs, and early mother-infant separation are used unnecessarily (1). Clinicians write and talk about the ideal of evidence-based obstetrics, but do not practice it consistently, if at all.*

Why do women go along with this stuff? In this Roundtable Discussion, Part 2, we asked some maternity care professionals and advocates to discuss this question. (BIRTH 33:3 September 2006)

“Why does anybody go along with this stuff?”

Why does anybody go along with this stuff? As a society we have come a long way from the 1960s and 70s, when women and their supporters marched on the hospitals to demand that birth become “humanized.” The result was “family-centered maternity care,” and we thought that the battle was over. And now you can get your family-centered cesarean at a rate of 30 percent in some countries. And not many are complaining!

Why? Because we are a terrified, risk-averse society, and because birth is no more immune to this societal trend than we are to television ads for “ask your doctor . . . for . . .” something for your high cholesterol, or for your arthritis, or for your thinning hair, facial wrinkles, or your lousy sex life. Pop a pill and carry on being fat and out-of-shape, while you expect to die suddenly at age 90 in the middle of sexual intercourse. We demand it of society, the medical profession, ourselves.

Meanwhile, women—pregnant for the first time at 35 to 40 years of age, having a professional or other job that they need, and having had infertility prob-

lems due to the delayed childbearing—are asking for a preemptive cesarean section without indications for themselves or their fetus. Are they wrong? And is the situation of supported or unsupported, induced, monitored, epiduralized, vacuumed, forceped, and ultimately, c-sectioned vaginal birth environment so bad that a prominent obstetric trialist has said that cesarean section by choice is rational for some women? And recent studies have contributed to this dystopic environment: post-term induction, term breech, group B streptococcus and glucose and other screening. And how did that happen?

It happened because we let it happen. Society, in its fear in the early 1920s, fear for mothers and babies who were dying, ceded control over childbirth to surgeons, who employed episiotomy and outlet forceps routinely, and later, when they became safer, cesarean sections, to solve the very real problems of childbirth at the time. And in the process, gynecologists became **obstetrician-gynecologists**. And we now wonder that our surgical saviors come up with surgical solutions to (urinary and rectal incontinence and sexual problems) that are not nearly as frequent as we have been led to believe.

But we want to believe that these problems can be prevented. And women and their partners go along with this stuff because they and we are afraid and want to be ever youthful. And because the “perfect” child is more important than the perfect birth. And

will the perfect child, born by elective cesarean section, be looked after by the perfect parents—who will change the dirty diapers, take a year of parental leave, put careers on hold, and study child psychology??? Ummmmm. Now that is one to study!

And women go along with it because they are largely getting what they want. The most risk-averse of them select obstetricians for normal pregnancy and birth. The least risk-averse select midwives for home birth, attended by unregistered and untrained so-called “midwives,” followed by those who want proper midwifery care in a home birth, followed by those who want a midwife and an epidural. The latter select hospital birth with a midwife or a like-minded family doctor. And those who are confused or uninformed, or have no choice—or truly love their family doctor—choose a family doctor. In the end everyone is happy in their niche-market world.

So women go along with this stuff because we have taught them to go along with it, in so-called childbirth education classes (mostly teaching women to be compliant), books (*What to Expect When . . .* blah blah blah). And their mothers, the now grandmothers from the 1960s and 70s, who fought for family-centered maternity care . . . they are not complaining much. They are worried about breast cancer and osteoporosis.

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“Women don’t know what they don’t know”

Why do women accept distorted, unscientific, externally manipulated birthing that serves the interests of others rather than demanding woman- and family-affirming childbirth consistent with their own capacities and interests? These thoughts refer to the situation in the United States.

Culture. Technology-intensive childbirth is the norm for healthy women. A tiny minority of women experience physiologic labor. Women don’t know what they don’t know. They generally lack an understanding of their own childbearing capacities and lack the ability to critically assess prevailing approaches.

Socialization. The dominant birthing ethos is presented and reinforced by the media, experiences and advice of friends and family members, prenatal visits,

predominant hospital-based childbirth education, and most books and websites that inform and advise pregnant women. Inappropriate labor and birth practices appear justified, even necessary. Many widespread interventions lack scientific support as routine measures, have multiple adverse effects, and lead to use of other consequential interventions to monitor, prevent, or treat these harms; yet this system failure is presented and appears to women as routine failure of their own bodies (“inadequate pelvis,” “failure to progress,” “failed induction,” etc.).

Capitalism. Large-scale North American studies of birth in out-of-hospital birth centers and at home demonstrate that few women truly need technology-intensive care around the time of birth. Yet through powers of advertising, sales representatives, industry-sponsored “education,” gifts to providers, and other measures, a never-ending series of new and ongoing drugs, devices, tests, breastmilk substitutes, and more are applied to mothers and babies. This large, vulnerable, and well-insured population is attractive to those seeking profits. Forces of capitalism are very difficult for mothers (and other stakeholders) to resist.

Professional autonomy. The United States obstetrical community sets its own standards and experiences very limited oversight and accountability. Few U.S. obstetricians have been involved with the international movement for evidence-based maternity care. Despite the important leadership of numerous individuals, rigorous adherence to the evidence-based paradigm is not central to their predominant professional cultural ethos. Although midwives and family physicians generally provide maternity care that is more consistent with best available evidence, they are politically vulnerable as maternity care providers and only a small proportion of childbearing women has access to their services.

Trust. Few women take an active role in selecting their caregiver, birth setting, and specific forms of care. Most assume that the care they receive is of high quality and in their best interest. They are poorly informed about evidence-based practice, benefits and harms of common practices, practice variation, the importance of informed choice, and their maternity rights. Most look to their caregivers for information, guidance, and safe, effective care. Oxytocin may play a role in fostering increased trust around the time of birth, whether warranted or not. Other stakeholders also count on and defer to health professionals to provide appropriate care.

Fear. Women fear problems with their babies, and many are afraid of labor pain and other aspects of

birth. They are often vulnerable, dependent, and willing to do whatever they have been led to believe might help to ensure a well baby and control of birthing processes. Narcotics, other drugs, and birthing environments may further impair emotional states.

Parity, new responsibilities. Most women who give birth do so just once or twice. It is especially difficult for first-time mothers to decode what is happening to them and why. Experienced mothers tend to be less vulnerable and to receive more appropriate care than first-time mothers. Although experienced mothers are more discerning about childbearing, major new concerns, such as demands of caring for one or more older children, and of juggling employment and family life, capture their attention. Mothers' awareness of the dynamics of maternity practice and capacity to advocate for themselves and for other women are limited, and their babies are utterly dependent.

Effective policies and programs are urgently needed to help ensure that this priority population receives safe, effective, respectful care that makes wise use of finite resources.

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“It is not quite that simple. . .”

Women are as capable as ever in dealing with the physical and psychological challenges and changes that come along with normal childbearing. Participating in maternity care, however, is far more challenging. The frustration expressed in the question, “Why do women go along with this stuff?” implies that women have choices and are making poor ones. It is not quite that simple. The fact is that many women have few choices, but even when they do, they tend not to question their care. They want to believe “doctor knows best” because they need, during this vulnerable time, to trust their care providers. If they are lucky, they have midwives or doctors who share decision-making as a matter of course. Most women are not so lucky.

Those who do not want to “go along” must research the options and decide what’s best for them. They have to find out if those choices are available where they live and are part of their health care coverage. Then, they negotiate with a care provider or switch to a more suit-

able one. This work requires much self-confidence and determination, and must be done by the end of pregnancy. Exercising informed choice may also mean being labeled by the professionals on whom she depends as “difficult,” untrusting, selfish, or ignorant. All this amounts to an impossible burden for most women.

Does this mean that women should accept whatever care they are given? It does not, but it does mean that birth activists who are wringing their hands over the apathy of “today’s woman” should not blame the woman for being weaker than the monolithic system in which she finds herself.

We must recognize that each woman is a transient stakeholder in the maternity care system, remaining involved as a recipient for only a few years, while care providers and hospitals are involved for generations or more. Only after becoming pregnant does she discover just how restrictive the customs and standards of care are. Whereas most women assume these customs are based on good reasons, those who want something different must negotiate through a morass of deeply entrenched customs and circular thinking that would frustrate or stop even the most self-confident and well-spoken client.

There has to be a better way. Many “alternatives” (including not using certain tests or procedures) are safe and cost-effective. Many enhance women’s satisfaction with their childbirths. The problem with such alternatives is that if they are to become more than occasional exceptions for a few vocal women, constant pressure is required to achieve real changes by health care providers and institutions. It is unlikely that a powerful consumer movement will materialize, because most consumers move on to other interests and obligations after completing their childbearing. (A few, thankfully, remain involved, becoming birth activists, writers, doulas, childbirth educators, or care providers.)

For change to take place so that women don’t have to “go along” with the usual, there must be a critical mass of courageous, committed, and stubborn “insiders”—influential care providers, administrators, health insurers (and editorial writers!)—who promote flexibility and safe and sound options. Without such a partnership between childbearing women and powerful opinion leaders, women are sentenced to “go along with this stuff.”

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“Pain and gain”

Recently, the Chief of Ob/Gyn Anesthesia at a prestigious American hospital questioned me about an American pop star who had given birth by elective cesarean, asking if she might be “an icon of a modern generation of women—strong, independent, articulate, informed, and rejoicing in the ability to have virtually pain-free childbirth? Even the ability to choose an elective cesarean, as she did?” For all my concern over the massive and unnecessary use of interventions in birth, I am coming to believe this anesthesiologist is right.

For women in the 1920s, the ability to bottle-feed was the “war cry of a generation,” as one novelist said, because this technology freed women from being tethered to their houses, allowing them to move around in the world. For women today, the epidural means freedom from pain, the electronic fetal monitor means freedom from fear (an illusion of course, but a powerful one), and the elective cesarean means freedom from uncertainty (another, even more powerful, illusion). As my interviews in the 1980s and early 1990s with 100 women indicated, and as a more recent United States survey by the Maternity Center Association showed, lots of women have all these technologies, lots of them want all these technologies, and only a few of them resent, resist, or refuse these technologies. Birth-giving women, like everyone else, tend to want what the society values. And what this technocratic society values is high technology in almost every aspect of life.

When we are hot in the United States, we crank up the air conditioning—why should we be uncomfortable when the technology to keep us cool is available at the push of an electronic button? When we are scared of robbers, we install burglar alarms. When we want to go to the store that’s only a few blocks away, we drive. We know the exercise would be valuable, but we schedule that in at the high-tech gym; walking to the store is definitely not on the schedule—who has time, and who wants to carry home all those groceries?

So why would we want to walk during labor? We might decide to run a marathon for the challenge—“no pain, no gain”—but we sweat at our convenience when we schedule it in. During labor, which now we can also schedule, we barely even start the race—we just take a taxi to the finish line. Labor and birth are not about achieving physical fitness, and there are few around us to talk about the enormous gain we could achieve from enduring and transcending the pain for the ineffable gain of giving birth on our own.

So I am constantly amazed and delighted when a former student or a friend writes or calls to tell me

that she had a natural childbirth because of my influence, because I did tell her what it’s worth, because I tried so hard to convey the magic and meaning of the “no pain, no gain” approach to birth. Some women want that magic because they realize in advance what it might mean, sometimes because it’s a part of them, and sometimes because they hear it from the right person at the right time, and it sticks. But most women don’t hear it at the right time from the right person, and a lot of women don’t hear it at all.

While the daughter is having an elective cesarean, her well-to-do mother may be having a tummy tuck and a facelift. And if the daughter is from a poor family, her mother is likely insisting that she receive “the best care”—high-hospital, high-tech care that may not have been available to her mother or her grandmother, and thus seems all the more desirable to the daughter. Our bodies are now under our own control, to a far greater extent than ever before. And our medical caretakers, our friends, and indeed almost everyone around us is using technology to control as much of life as possible. So why should women listen if a few thousand birth activists and those granola-type proponents of natural living try to tell them that the price of such painless, fearless, and perfectly timed birth is too high?

The only reason why the United States does not have the same high cesarean rates as China (50%), Taiwan (50%), Puerto Rico (48%), Argentina (40%), Mexico (40%), and Brazil (38%) is because of birth activists, who for over 30 years have been critiquing obstetrical procedures, pointing out the evidence, and educating women as best we can. We have staved off the cesarean onslaught for three decades, but we are losing that battle, in part because of (1) the outrageous misinterpretation of several recent studies, which has practically ended the vaginal birth after cesarean (VBAC) option (except at home) for American women, and (2) the American College of Obstetricians and Gynecologists’ statement on the ethical rightness of elective cesareans, which freed doctors from their previous compunctions about performing unnecessary surgery. Some United States hospitals have already reached 50 percent cesarean rates, and others are headed that way.

So in some ways we birth activists are failing, defeated by the evidence that would, if rightly interpreted, support our stand, and more profoundly by unidirectional sociocultural trends. But the women who write me almost every week to tell me that I made a difference in their births, and thus their lives, are also telling me that we can, if we keep on trying, keep open the options for normal, natural, and enormously satisfying and fulfilling births for the women in whom we can light, or fan, the spark of desire to skip the taxi

and run the whole race on their own, because they understand that the flow of hormones and love and empowerment that result will benefit them, and their babies, for life.

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“Your baby’s most dangerous trip . . .”

Most women who “go along with this stuff” today entered the reproductive phase of their lives after 1980—a time of high and increasing use of these obstetric methods in the United States. Since then, midwives, epidemiologists, and public health-oriented physicians have become increasingly aware of the lack of benefits and higher costs and risks associated with routine use of obstetric interventions—concerns they voiced within professional circles and journals. The general public, on the other hand, mostly didn’t—and still don’t—have a clue, believing that American health care, in general, is the best in the world and that the more high tech and sophisticated the care, the better it is. Doing without such advanced care seems silly if you are lucky enough to have access to it.

More women are working during pregnancy, delaying their first planned child, having babies at older ages, raising smaller families (one or two children), or using sophisticated medical methods to achieve conception. As a result of these trends, more expectant parents see their pregnancy as high risk, a lucky achievement. If a pregnancy or newborn is lost, it may be irreplaceable. Screening for fetal defects and legal abortion allow parents to decrease the risk of an imperfect baby.

Accepting the risk of a poor pregnancy outcome, which was part of American culture throughout most of its history, is being lost. All babies should be perfect, and prospective parents should do everything possible to predict, detect, and avoid a problem. Understanding that doing less can be safer and better than doing more in some situations rests on mastery of a fairly complex body of knowledge. Many obstetricians feed the perception that “Your baby’s most dangerous trip is the one through your birth canal. You can avoid that danger by avoiding the trip—it is easy to pop the baby out through your belly; a c-section can be scheduled for a convenient time, and you can avoid pain altogether!” The average American is amazed by—and often distrustful of—any assertion that a cesarean section is not

the safest form of birth *for the baby*, even if it is not for the mother.

Parents know that they are not experts in pregnancy care and that the consequences of problems during pregnancy and birth can be catastrophic. They are anxious about the perfection of their baby and feel vulnerable. To be comfortable, they must feel confident in the opinion and advice of their primary physician or, less common, of their midwife. Other voices carry less authority. False positives and iatrogenic risks are not familiar concepts to most people, and the possibility that electronic fetal monitoring, a cesarean section, or other interventions could produce more problems than they prevent is counterintuitive. In addition, pregnant women feel in no position to argue against an authority figure, especially the one on whom they want to depend. This is true throughout pregnancy, but even more so during labor.

Unlike the situation for members of groups who have fought for needed changes in other areas of life, pregnancy is a fleeting condition and most pregnant women work outside the home. The critique of obstetrics that made some gains in the 1960s and 1970s was fuelled by the energy of well-educated women who did not have full-time careers and thus could commit substantial time and persistent effort to educate and support other women to be proactive consumers of health care. Today most well-educated assertive pregnant women are overwhelmed by just juggling pregnancy, and then mothering, with holding down a job. Low-income, poorly educated women are overwhelmed with just surviving, have less access to sources of information that challenge the status quo, and have even less confidence in their ability to question a physician. And they may have a particular desire for use of obstetrics methods that they see as better *because* they are high-tech, presumably expensive, and available to private patients.

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“We must continue to press forward”

Our obstetrics system predominates. It has evolved for well over a century and is deeply rooted in our culture. In part designed to help women with serious medical problems, it does not really respect or serve the interests and needs of *most* childbearing women. It has its own imperatives—among others, to foster

practitioners' expertise and promote their reputations; to consolidate and expand its control of hospitals and medical education. It determines hospital hierarchy and protocols, allowing for little deviance from fixed rules and regulations, requiring every woman's labor to adhere to a predetermined time schedule, for example, or contravening tried-and-true midwifery practices.

The system feeds on fear. Those in charge define every birth as a medical event. Most practitioners and mothers-to-be are convinced that childbirth is scary and unsafe, that women can't give birth on their own and require a series of mechanical and pharmacological interventions. Obstetricians and obstetric nurses are educated and trained in those very beliefs: Who better to practice on than "patients"? Than the women who know little about labor and birth? Than all the others who have been frightened by harrowing birth stories?

The media (will we ever identify exactly *who* decides what article to print, which TV segment to show?) encourages this dependence, only occasionally mentioning "alternatives." It both drives and reflects a culture that worships technology, convincing young women today that drugs and devices eliminate risk, guarantee safety, provide *real* "choice" and *real* "control." Current obstetric propaganda names the intensity of contractions as unbearable "suffering," which no woman should have to endure for a moment, and as "pain" so great that it prevents us from experiencing the joy of giving birth. And increasing numbers of young women submit, believing it all.

The professionals' debates reflect the status quo. Concentrating narrowly on when to induce labor or insert an epidural or perform a cesarean, these discussions relegate to oblivion the broad concept of a "cascade of interventions," this longstanding and useful analysis of the debilitating effects of sequential medical practices.

Dedicated physicians, midwives, researchers, and childbirth activists have proved over and over again (their conclusions based on clear evidence) that many routine interventions are unnecessary, counterproductive, harmful, even dangerous, and that midwifery care is not only better and safer for women, but cost-effective. Why not acknowledge these findings and alter obstetrical practice accordingly? Because conventional hospital routines, machinery and drugs are the bread and butter of obstetrics. To respect and allow natural physiological birth, the existing system would have to change its very nature, to see itself as complementary and subsidiary to midwifery wisdom and techniques; in large part, it would have to melt away, used (appropriately) only when absolutely needed.

Thus, many practitioners go along with the system because they believe in it. Others hope to change it from within when possible, or at least make it as congenial and flowing an experience for women as possible. Too much resistance (or even a little bit) leads to being labeled a "troublemaker." It can mean losing a job, ruining a reputation, or being seen as lacking credibility. Too many of us are simply afraid.

As activists, educators, and midwives, we have tried hard not to "go along." We have worked night and day to make important, even marvelous inroads—especially since the "open window" of the 1970s—to witness the re-emergence of midwives, the development of birthing centers and family-centered birth, the creation of doulas as women's newest attendants, the wealth of informative journals, websites, and organizations. Yet we continue to confront a deeply rooted system, changeable only up to a point, stronger than all of us put together. We should not allow its "language" of **risk** and **fear** and even **convenience** (in discussions about elective cesareans, for example) to infiltrate our own. It is up to us to keep alive the birth stories of those women who have been empowered by their experiences, to inspire the next generation of mothers. Let's advocate fiercely for women's rights to be respected, although increasing numbers of women give them up without knowing that they are doing so.

A personal note: My daughter-in-law, a woman very much in touch with her body and her desires, is *so* happy to be pregnant for the first time. She's looking for a midwife. Even this early she has encountered people who evince caution, fear, uncertainty. She will not acquiesce to anything that does not nourish her confidence, her joy. She will need an environment surrounding her with love, optimism, comfort, gentle guidance, strength, and a practitioner knowledgeable about birth in general who respects and loves the elegant processes of natural labor and birth. If only she could find a system of woman-centered care containing all these elements close at hand.

We will need a large collective effort to withstand the medicalization of birth. Despite the odds, we must continue to press forward to create a culture that honors and values women's autonomy, power and potential, and the art and craft of true midwifery.

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