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|  | **Friday, February 09, 2007** |  |
| **Birth**  **In the News**  **~ 2006 &**  **2007 ~**  **Midwifery, Planned Home Birth & related Topics** |  | American College of   Community Midwives  **A professional organization for community midwives** |
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| [**January thru July 2006**](#1fob9te) | [**August 2006**](#30j0zll) | [**September 2006**](#gjdgxs) |
|  | **Archive for** [**2003**](#3znysh7) | **January & February  2007** |

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| Childbirth shakeup means NHS unit closures  **Tuesday February 6, 2007** |
| UK ups childbirth safety with closures  [**The Guardian**](http://www.guardian.co.uk/) **~ John Carvel; Social Affairs editor**  Plans for a drastic reduction in the number of NHS hospitals in England providing full childbirth facilities for mothers and specialist medical care for children will be announced by the Department of Health today. It is part of a move to put more complex clinical work into regional centres of excellence. [more distant, centralized services]  Ministers have decided to **offer every expectant mother three options** for the delivery of their baby. **By 2009 they will be able to choose between**:    **1.  Home birth supported by a midwife**  **2.**  Birth in a **local midwife-led unit**, based in a hospital or community clinic **promoting natural births**  **3.**   Birth at a hospital, supervised by a consultant obstetrician, for mothers who may want epidural pain relief or may need specialist care to deliver safely.  A proposal to offer mothers more choice was included in Labour's 2005 manifesto and the implications will be set out today in a report by Sheila Shribman, the government's maternity tsar. She will seek to convince mothers who need the care of a consultant that they will be treated more safely at a specialist regional unit than at their local multipurpose NHS hospital.  The regional units will be able to provide full teams of consultants, midwives and nurses at any hour of the day or night throughout the year, using the latest technology. But the proposal implies further controversial closures of consultant-led maternity units at other hospitals.  Dr Shribman's reports on maternity and paediatric care will not spell out how many hospitals should lose consultant-led services, or where they should be. These decisions will be left to local NHS managers after public consultation.  Ministers and cabinet members who have campaigned over the past few months against the closure of maternity units affecting their constituents have included Hazel Blears, the Labour party chair, Jacqui Smith, the chief whip, and Ivan Lewis, the health minister.  Dr Shribman will say the concentration of hi-tech services into centres of excellence would improve both safety and care. "We've always needed to make changes to deliver improvements in quality and these reports outline the way forward for these important services."  Dr Shribman will call for a similar overhaul of paediatric medicine. Children and young people with long-term medical conditions would benefit from care at clinics and health centres closer to home, keeping visits to hospital to a minimum. But the treatment of seriously ill children should be provided in specialist centres, involving longer journey times  [**Printer friendly PDF**](http://docs.google.com/PHB_20006/UK%20ups%20childbirth%20safety_07.pdf) |

[.](http://docs.google.com/PHB_20006/UK%20ups%20childbirth%20safety_07.pdf)

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| **C-section lawsuit** |
| Jan 1, 2007 1:09 am (PST)  <http://www.childbirthsolutions.com/articles/birth/cesarean/cesarean_lawsuit.php>  A Plaintiff's Verdict: Meador v. Stahler and Gheridian  The $1.5 million award to a Massachusetts woman and her family in Meador v. Stahler and Gheridian made news as a rare instance of a malpractice judgment based on an  **allegedly unwanted and unnecessary cesarean section rather than a failure to perform such an operation**.  The plaintiff, Mary Meador, did not claim that the procedure was negligently performed or that the rare and disabling physical complications that resulted from it (which left her largely bedridden and unable to work or meet her family responsibilities for several years) were foreseeable. Instead, she claimed that the defendant **obstetricians had misrepresented the risks of the alternative procedure (vaginal birth after prior cesarean) and ignored her persistent pleas for this alternative**. Moreover, she alleged, they compelled her passive assent to the surgery in an emotionally coercive manner while she was progressing normally in labor, despite their having previously agreed to such a trial of labor.  Because the consequences of the cesarean were unforeseeable, and because Meador had signed a consent form for the surgery (to be used in case of emergency), this case did not meet the technical requirements specified under Massachusetts law for an action  based on informed consent. Instead, the case was brought on the theory that the physicians' failure to obtain the patient's informed consent constituted substandard, negligent medical care. The forensic psychiatrist's expert testimony emphasized that the pro forma signing of a consent form did not constitute true informed consent, especially in light of the physicians'  **alleged disregard of the patient's expressed wishes and their inaccurate representation of the risks and benefits of the approach she preferred**.  The psychiatrist also explained to the jury how Meador's life history left her vulnerable to experiencing the **denial of informed consent as a highly traumatic event**. Having coped since childhood with serious illnesses in her family, Meador had viewed doctors and nurses as nurturing figures who helped her gain control of potentially tragic situations. She had learned that choice was still possible even amidst illness and death. She had even been inspired to become a nurse herself and to teach this discipline to others. Thus, when she **experienced a sudden loss of choice and control during childbirth, she reacted with intense fear and horror and felt she had been betrayed by health professionals**, whom she now feared and mistrusted. In this way she lost her accustomed strategy for coping with life. Moreover, having helped hold her original family together in the face of tragic illness, Meador saw the family she had created torn apart by her sudden and devastating loss of control in a medical situation. The jury's recognition of **the importance of the emotional facts of the case** was highlighted by its awarding almost one-third of the total damages for loss of consortium.  Thus, it was not simply the physically disabling consequences of the surgery, but the loss of personal decision-making power concerning her body, her health, and the birth of her child, that caused Meador to suffer from Post-Traumatic Stress Disorder. Similarly, her husband's experience of loss of consortium was exacerbated by **the physicians' failure to consult him to interpret his wife's wishes** during labor**. Instead of having participated in a true informed-consent process, he was left to feel powerless and helpless**. In this way, forensic psychiatric testimony established a persuasive causal link between the **lack of informed consent and the physical and emotional damages suffered** by the patient and her family.  Source:  [http://www.forensic](http://www.forensic/) < <http://www.forensic-psych.com/>> -psych.com/  <[http://www.forensic](http://www.forensic/) < <http://www.forensic-psych.com/>> -psych.com/>  <  [http://geo.yahoo.com/serv?s=97359715/grpId=3915960/grpspId=1705062138/msgId](http://geo.yahoo.com/serv?s=97359715/grpId%3D3915960/grpspId%3D1705062138/msgId) |

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| **Dissecting the C-section birth** |
| ERIN AIRTON -- 24 Hours-Vancouver  Oct. 19, 2006  Women who have caesarean sections for the births of their babies are more likely to end up with future ectopic pregnancies and stillbirths, issues around infertility, and increased newborn breathing difficulty.  These major side-effects don't seem to stop the growing number of B.C. women handing over the most important physical moment in their lives to their obstetricians who blindly follow a medical program rather than standing up for normal birth.  Driven by fear, women have bought into the "as long as the baby is healthy" mantra espoused by doctors too impatient to allow births to unfold as they should.   |  | | --- | |  |   The World Health Organization thinks that 10-15 per cent maximum of all births warrant a caesaren section. In Vancouver, the rate is 27 per cent - almost one in the three births is conducted as surgery, rather than a loving, natural experience. In some B.C. communities, the rate is over 40 per cent.  Dr. Jan Christilaw from B.C. Women's Hospital spoke earlier this year at a conference aiming to get to the bottom of this sad phenomenon. She feels that women are scared of birth and because of this fear, they are more likely agree to drugs to speed up labour and numb the pain.  Known as a "cascade of interventions," this scenario often ends up in a C-section for the mother, giving her permanent physical and psychological damage.  I can't count how many times I've heard women announce that they refuse to labour without an epidural, not knowing the negative outcomes that could flow from this choice.  Doctors care more about getting the birth done quickly than supporting a woman emotionally through the most amazing experience in her life. If they could knock us out completely, as they did during the 1950s, it would make their jobs much easier.  Due to this approach, less than 45 per cent of women believe birth is a natural process that should be left alone. The path to normal birth isn't like following a road map, it unfolds like a story, with unexpected plot twists.  Unfortunately, many doctors want a predicable straight line and aren't trained nor have the patience to just let it happen, no matter how long it takes.  According to Dr. Christilaw, the main factor that predicts C-section rates is the obstetrician. Some doctors have rates as low as eight per cent and others are way above even our high provincial average.  Pregnant mothers need to shop around for an obstetrician with a low C-section rate. Or better yet, look into midwifery care which, using standards supportive of women's needs and a different understanding of birth, reduces much of the fear and pain that can lead to unnecessary caesarean sections.  This week Canadian midwives are meeting in Ottawa for their annual conference. More information about the midwifery option in Canada can be found at:  **www.canadianmidwives.org** |

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| **September 2006**  **Original article published in the New Zealand Heard,**  **Synopsis Copied from "The SF Bay Area Homebirth Collective Newsletter"** |
| **Secretary of Health Urges Mothers to Opt for Planned Home Birth**      In an unprecedented move by the Secretary of State for Health, British women are being advised to give birth at home as part of a revolution in childbirth policy in Britain that will reverse decades of medical convention.      Patricia Hewitt, the Secretary of State for Health, is to "challenge the assumption", prevalent since the 1970s, that the safest place to give birth is in the hospital and that home birth can be dangerous.      With what is being billed as a historic shift in the politics of childbirth, British doctors will be told to offer all pregnant women the chance to deliver their baby at home with the help of a midwife and their own choice of pain relief.      According to The Independent, Tony Blair's Labor Government is planning a "strategic shift" in childbirth policy away from hospital delivery and has commissioned research to support the case for homebirth, and "challenge the assumption that the birth should take place in hospitals".      The Secretary of Health wants to "demedicalize" pregnancy. Homebirth was a safe option, she said, citing new college statistics on 1300 home births which showed success on a range of measures including the length of labor, pain relief and neonatal resuscitation needs.      Preliminary research by the National Institute for Health and Clinical Excellence shows that women who give birth at home may be more satisfied with the experience than those who give birth in delivery rooms.  [**Print-Friendly PDF file**](http://docs.google.com/Political_Action_2006/BBC_UK_urgesPHB_Sept06.pdf)**for this articles**  **Original Source from BBC web site ~** 15 May 2006  **UK Government to promote home births -**  **Home births are still a tiny minority**  Women will be given every encouragement to give birth at home if that is their preferred option.  The Department of Health says it wants to end assumptions that a hospital is always the best place to have a baby.  Health Secretary Patricia Hewitt has commissioned work into how to make home births more available.  The National Childbirth Trust welcomed the move, saying currently women were often discouraged by doctors from considering a home birth.  We are committed to offering all women the choice of how and where they give birth  Department of Health  Expectant women will now be given more choice about giving birth either in hospital, at a birthing centre or at home.  However, women with a history of complications will still be urged to give birth in a hospital.  Office of National Statistics data showed there were 15,198 home births in 2004, up 7% on the 14,204 in 2003.  However, this represents just 2% of the total number of births each year in the UK.  **Choice**  A Department of Health spokesperson said: "We are committed to offering all women the choice of how and where they give birth, and what pain relief is available.  "The government underlined its commitment to delivering choice in maternity services in its 2005 manifesto, the National Service Framework for children and maternity and the recent White Paper Our Health, Our Care, Our Say.  "All these services will be offered within the context of what is safe and clinically appropriate care for each individual woman.  "We also want every woman to be supported by a named midwife throughout their pregnancy, and for services to be linked to those provided in Children's Centres."  Belinda Phipps, NCT chief executive, said flawed research from the 1970s which falsely concluded home births were not safe had informed government policy for decades.  In fact, she said there was a well of evidence to suggest that home births were at least as safe as giving birth in hospital.  Patient satisfaction levels were higher for home births, and simply booking a home birth led to a halving of the Caesarean section rate, she said.  "It has taken 30 years for the government to realise that the policy of pushing every woman giving birth into hospital was misguided. It would be lovely to see it reversed," she said.  **'Staffing shortages'**  Dame Karlene Davis, general secretary of the Royal College of Midwives, said: "Women should have the freedom to choose how and where they give birth."  "This will benefit the majority of women, who are able to have a normal birth, but at present are denied the choice mainly because of ongoing staff shortages."  However, she warned that the initiative could be stalled without sufficient resources.  Shadow Health Secretary Andrew Lansley said giving women a choice over where they gave birth was a fundamental right.  But he added: "It comes as no surprise that as hospitals are facing critical cut backs because of deficits, the Health Secretary declares that more women should give birth at home.  "There are real concerns over the provision of services: at least three-quarters of maternity units are experiencing some level of staffing shortage, half of all trusts are thought to be operating a recruitment freeze and the number of home visits by midwives is declining in some areas."  [**Print-Friendly PDF file**](http://docs.google.com/Political_Action_2006/BBC_UK_urgesPHB_Sept06.pdf)**for above text** |
| **New York Times** |
| **Voluntary C-Sections Result in More Baby Deaths**  By NICHOLAS BAKALAR  Published: September 5, 2006  A recent study of nearly six million births has found that the risk of death to newborns delivered by voluntary Caesarean section is much higher than previously believed.    Infant and Neonatal Mortality for Primary Cesarean and Vaginal Births to Women with "No Indicated Risk," United States, 1998�2001 Birth Cohorts (Birth: Issues in Perinatal Care)    Researchers have found that the neonatal mortality rate for Caesarean delivery among low-risk women is 1.77 deaths per 1,000 live births, while the rate for vaginal delivery is 0.62 deaths per 1,000. Their findings were published in this month�s issue of Birth: Issues in Perinatal Care.  The percentage of Caesarean births in the United States increased to 29.1 percent in 2004 from 20.7 percent in 1996, according to background information in the report.  Mortality in Caesarean deliveries has consistently been about 1� times that of vaginal delivery, but it had been assumed that the difference was due to the higher risk profile of mothers who undergo the operation.  This study, according to the authors, is the first to examine the risk of Caesarean delivery among low-risk mothers who have no known medical reason for the operation.  Congenital malformations were the leading cause of neonatal death regardless of the type of delivery. But the risk in first Caesarean deliveries persisted even when deaths from congenital malformation were excluded from the calculation.  Intrauterine hypoxia � lack of oxygen � can be both a reason for performing a Caesarean section and a cause of death, but even eliminating those deaths left a neonatal mortality rate for Caesarean deliveries in the cases studied at more than twice that for vaginal births.  �Neonatal deaths are rare for low-risk women � on the order of about one death per 1,000 live births � but even after we adjusted for socioeconomic and medical risk factors, the difference persisted,� said Marian F. MacDorman, a statistician with the Centers for Disease Control and Prevention and the lead author of the study.  �This is nothing to get people really alarmed, but it is of concern given that we�re seeing a rapid increase in Caesarean births to women with no risks,� Dr. MacDorman said.  Part of the reason for the increased mortality may be that labor, unpleasant as it sometimes is for the mother, is beneficial to the baby in releasing hormones that promote healthy lung function. The physical compression of the baby during labor is also useful in removing fluid from the lungs and helping the baby prepare to breathe air.  The researchers suggest that other risks of Caesarean delivery, like possible cuts to the baby during the operation or delayed establishment of breast-feeding, may also contribute to the increased death rate.  The study included 5,762,037 live births and 11,897 infant deaths in the United States from 1998 through 2001, a sample large enough to draw statistically significant conclusions even though neonatal death is a rare event.  There were 311,927 Caesarean deliveries among low-risk women in the analysis.  The authors acknowledge that the study has certain limitations, including concerns about the accuracy of medical information reported on birth certificates.  That data is highly reliable for information like method of delivery and birth weight, but may underreport individual medical risk factors.  It is possible, though unlikely, that the Caesarean birth group was inherently at higher risk, the authors said.  Dr. Michael H. Malloy, a co-author of the article and a professor of pediatrics at the University of Texas Medical Branch at Galveston, said that doctors might want to consider these findings in advising their patients.  �Despite attempts to control for a number of factors that might have accounted for a greater risk in mortality associated with C-sections, we continued to observe enough risk to prompt concern,� he said.  �When obstetricians review this information, perhaps it will promote greater discussion within the obstetrical community about the pros and cons of offering C-sections for convenience and promote more research into understanding why this increased risk persists.�  [**Print-Friendly PDF file**](http://docs.google.com/Political_Action_2006/NYT_3XbabyDeath_ECS.pdf) **for this article** |

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| **August 2006**  **CNN.com  ~** |
| **Caesarean Birth Triples Maternal Death Risk**  Los Angeles, California (Reuters) ~ A Caesarean delivery more than triples a women's risk of dying in childbirth compared to a vaginal birth according to a new study from France.  The risk is still quite small, but many developed countries have seen a dramatic rise in the number of Cesarean performed each year **as \*more women elect to avoid a vaginal delivery.   (The *Listening to Mothers* 2004 Survey refuted the idea that increased CS rate were the result of did "women electing to have C-section in order avoid a vaginal delivery", but instead that medical caregivers had**  Researchers, led by Catherine Deneux-Tharaux of the Maternite Hospital Tenon in Paris, looked at 65 maternal deaths recorded in the French National Perinatal Survey from 1996 to 2000.  All of the deaths followed birth of a single child and were not due to conditions existing prior to delivery. The women had also not be \*hospitalized during pregnancy (\*editor's note -- hospitalization during pregnancy was used as a statistical marker for maternal or fetal disease, therefore a cohort of maternal death in in women who did not need any antepartum hospital care connotes the death of  healthy women with a normal pregnancies).  The risk of death after childbirth was increased whether or not the Caesarean was performed before the onset of labor or during labor. The study was published in the September issue of Obstetrics and Gynecology.  Although rates of maternal death in most developed countries are relatively low -- US women have a \*1 in 3,500 chance of pregnancy-related death -- the incidence of maternal mortality has not significantly decreased in the last two decades, according to the American College of Obstetricians and Gynecologists (ACOG).  (\* Editor's note: Maternal mortality for vaginal birth is 1 out of 16,666 birth as compared to about 1 out of 5,000 for elective Cesarean section.)  [**Print-Friendly PDF file**](http://docs.google.com/Political_Action_2006/CNN_Triple_MatDeath_ECS_Aug2006.pdf) **for this article** |

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| **January thru June 2006** |
| **January 19, 2006**  [**Hospital Birth Disaster**](http://docs.google.com/AmputeeNecrotizingF_JAn06.htm) |
| **Feb. 2006**  [**ACOG Policy Statements**](http://docs.google.com/Political_Action_2006/ACOG_Mfry%26PHB_Policies_Feb2006.htm)  **on Non-nurse Midwifery (CPMs, LMs & NDs) & Planned Home Birth** |

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| **May 2006**  **U.S. has second worst newborn death rate in modern world, report says**  **2 million babies die in first 24 hours each year worldwide** |
| May 10, 2006 CNN~ By Jeff Green  KEY INDICATORS  The report listed 10 measures used to compile the **Mother's Index**:  # Lifetime risk of maternal mortality  # Percent of women using modern contraception  # Percent of births attended by skilled personnel  # Percent of pregnant women with anemia  # Adult female literacy rate  # Participation of women in national government    (CNN) -- An estimated 2 million babies die within their first 24 hours each year worldwide and the **United States** has the **second worst newborn mortality rate** in the developed world, according to a new report.  American babies are three times more likely to die in their first month as children born in Japan, and newborn mortality is 2.5 times higher in the United States than in Finland, Iceland or Norway, *Save the Children* researchers found.  Only Latvia, with six deaths per 1,000 live births, has a higher death rate for newborns than the United States, which is tied near the bottom of industrialized nations with Hungary, Malta, Poland and Slovakia with five deaths per 1,000 births.  "The United States has more neonatologists and neonatal intensive care beds per person than Australia, Canada and the United Kingdom, but its newborn rate is higher than any of those countries," said the annual State of the World's Mothers report.  The report, which analyzed data from governments, research institutions and international agencies, found higher newborn death rates among U.S. minorities and disadvantaged groups. For African-Americans, the mortality rate is nearly double that of the United States as a whole, with 9.3 deaths per 1,000 births.  Sub-Saharan Africa remains the worst place in the world to be a mother or child, with Scandinavian nations again taking the top spots in the rankings by the Connecticut-based humanitarian group.  Sweden heads the list, with Niger last. (10 worst and best)  The "Mothers' Index" in the report ranks 125 nations according to 10 gauges of well-being -- six for mothers and four for children -- including objective measures such as lifetime mortality risk for mothers and infant mortality rate and subjective measures such as the political status of women.  Charles MacCormack, president and CEO of *Save the Children,* said the report card "illustrates the direct line between the status of mothers and the status of their children."  "In countries where mothers do well, children do well," he said in a written statement accompanying the report.  But each year, according to the report, more than a half-million women die as a result of pregnancy and childbirth difficulties, 2 million babies die within their first 24 hours, 2 million more die within their first month and 3 million are stillborn.  **An unhealthy start**  As Americans celebrate Mother's Day on Sunday, "5,000 mothers will mourn the loss of the newborn they bear that very day in the developing world," said Anne Tinker, director of *Save the Children's* Saving Newborn Lives initiative.  "All children, no matter where they are born, deserve a healthy start in life," Melinda Gates wrote in a foreword to the report, which was funded in part by the foundation she runs with her husband, Microsoft co-founder Bill Gates.  MacCormack said "significant progress" had been made in reducing deaths in children under age 5 in recent years, but "we have made little progress in reducing mortality rates for babies during the first month of life."  Causes of death in the developing world were dramatically different from those in the developed world, the report said. In industrialized nations deaths were most likely to result from babies being born too small or too early, while in the developing world about half of newborn deaths were from infection, tetanus and diarrhea.  The newborn mortality rate in the United States has fallen in recent decades, the report said, but continues to affect minorities disproportionately.  Only 17 percent of all U.S. births were to African-American families, but 33 percent of all low-birth weight babies were African-American, according to the report.  The research also found that poorer mothers with less education were at a significantly higher risk of early delivery. The study added that in general lower educational attainment was associated with higher newborn mortality.  Tinker said some nations ranked high in part because they offer free health services for pregnant women and babies, while the United States suffers from disparities in access to health care.  "We can do better here, but what's really important is that we do something" in the developing world, she said.  The report said almost all newborn and maternal deaths take place in developing nations -- 99 percent and 98 percent, respectively. The newborn mortality rates were particularly high in countries with a recent history of armed conflict, including Liberia and Sierra Leone.  But the report also concluded that political will was more important than national wealth. A "newborn score card" ranking 78 developing nations found that **some relatively impoverished countries -- including Colombia, Mexico, Nicaragua and Vietnam -- fare better than others.**  Ranking at the bottom of the scorecard were Liberia, Afghanistan, Angola and Iraq -- countries where armed conflict and cultural practices impede newborn survival.  "It's tragic that millions of newborns die every year, especially when these deaths are so easily preventable," Gates wrote. "**Three out of four newborn deaths could be avoided with simple, low-cost tools that already exist**, such as antibiotics for pneumonia, sterile blades to cut umbilical cords and knit caps to keep babies warm."  **'The good news'**  The Mothers' Index -- which excluded some nations that lacked sufficient data -- highlights huge disparities between the nations at the top and the bottom of the list.  Compared with mothers in the top 10 countries, a mother in the bottom 10 was found to be more than 750 times more likely to die in pregnancy or childbirth.  In top-ranked Sweden, skilled personnel are present at nearly all births, but in bottom-ranked Niger, such help is available for only 16 percent of women in labor.  "The good news," said MacCormack, "is that we know what it takes to help these moms and children survive and thrive."  The report highlights the three areas it says have the most influence on child well-being: female education, presence of a trained attendant at birth and use of family planning services.  Educated women, the report said, are more likely to marry and give birth later in life, to seek health care and to encourage education for their children, including girls.  The report said that family planning and increased contraception use leads to lower maternal and infant death rates. Many women and children in developing nations, it said, die as a result of births that come at the wrong time -- too close together, too early or too late in the mother's life.  A 15-year-old mother holds her 9-day-old baby in Bangladesh, where **153,000 newborns die each year**.  [**Print-Friendly PDF file**](http://docs.google.com/Political_Action_2006/CNN_2ndWorst_PMR_US_May2006.pdf) **for this article** |

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| **News from the**  **2003 Archive** |

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|  | **Aug 2003 Column by Dr Joyce Brother**  [**Reply to Dr Joyce Brothers**](http://docs.google.com/Citations%20or%20text%2002/Dr%20J%20Brothers%20letter%2003.htm) **regarding one of her newspaper columns that used the misleading information in the Pang Study to    wrongly conclude that PHB is an irresponsible and dangerous choice ~ see original letter below and then read the Reply.**  **DEAR D.N.**:    Your daughter was lucky the first time, and you were lucky to have a healthy grandchild. I don't think you should argue, but I do believe you should let her know that a medical journal recently reported that the risk of neonatal death was almost twice as high when the delivery was begun in the home.  To prove how lucky your daughter was before, this research shows that the risk of death is even higher for first-time mothers.   ...... The risks of heart problems, respiratory disorders and many other unexpected problems occur more frequently in home births. |

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