Op-Ed piece on the Misuse of Pang Study, in response to ACOG's

December Letter to Medical Board of California

Flat Earth Obstetrics 2003 B.C.E  cooks the books

 on midwifery study, uses Arthur Anderson "slight-of-hand" bookkeeping methods

 to cover up the dangers of obstetrical interventions and high Cesarean surgery rate

[**ACOG Letter to the Medical Board of California**](http://docs.google.com/Scanned%20Documents%202003/ACOG%20MedBd%20take%202%20feb03.htm)

**December 20, 2002 RE:**

**SB 1950 -- eliminate home-based birth care as unsafe**

[**Letter to Editor ~ January 2003 Obstetrics & Gynecology**](http://docs.google.com/Letter_Ed_Pang_Jan03.htm) **(the Green Journal)**

[**Press Release**](http://docs.google.com/PressReleasePang%20Feb03.htm) **-- 3 page synopsis ~ Cal College of Midwives**

[**List of Home birth References**](http://docs.google.com/Citations%20or%20text%2002/index_of_research_on_home_birthUK.htm)**~** [**Dangers of Cesarean surgery / post-cesarean pregnancies**](http://docs.google.com/Medical%20Board%2002/Dr_Chase_%20Addendum_Jan03.htm)

[**Citation for CS / VBAC**](http://docs.google.com/Medical%20Board%2002/Dr_Chase_List_Jan03.htm) **article ~  August '02** [**Comprehensive Review**](http://docs.google.com/ACOG%20%20Hm%20Brth%20Study%20Aug%2002.htm) **of  Pang-Benedetti Study**

For more than a hundred years, vital statistics collected by the US government and peer-reviewed scientific studies have documented the safety of  home-based midwifery care for healthy women. [1,2,3, 30]  Historically, the form of non-interventive or 'physiological' management used by midwives has always been safer for normal birth (approximately 70% of pregnancies) than the medical and surgical methods preferred by obstetricians. [4,5,6]

|  |
| --- |
| Testimony on the efficacy of midwifery care was presented in 1931 to the  **White House Conference on Child Health** and Protection by the Committee on Prenatal and Maternal Care: Reed (1932) concluded:~  "that ...trained midwives  **surpass** the record of physicians in normal deliveries has been ascribed to several factors. Chief among these is the fact that the circumstances of modern practice induce many physicians to employ procedures which are calculated to hasten delivery, but which sometimes result in harm to mother and child. On her part, the midwife is not permitted to and does not employ such procedures. She waits patiently and lets nature take its course."  |

Professional midwifery is the form of normal maternity care used so successfully in Europe for the last 200 years. The five countries in the developed world with the *best mother-infant outcomes* use midwifery as the *foremost* *standard for healthy mothers with normal pregnancies*.

Even though the consensus of  research world-wide affirms this traditional choice as safe (and has done so for at least a hundred years), the obstetrical profession's historical distain for midwives has, over the last century, been vitriolic in its opposition. Their favorite slur for the first half of the 20th century was always some permutation of the charge that "midwives kill babies". In 1980 they characterized home-based birth care as �the earliest form of child abuse�. According to the obstetrical profession, the healthy woman�s right to determine the circumstances and manner of her birth is in conflict with the right of a normal baby to be �well-born�, which they insist requires the services of an obstetrical surgeon in an acute-care hospital.

A 1986 study of obstetrical opinions noted that 75% of surveyed obstetricians felt that their highest loyalty was to the unborn baby even if it required the use of coercion or court orders to force compliance of childbearing women who declined their medical advise. The underlying point of view is that only an obstetrician can understand the risks associated with normal pregnancy and childbirth, which would mean that doctors are the final decision makers. Mothers must inevitably be hospitalized and routinely exposed to interventionist care so that they, the doctor, can function as a surrogate parent or or state-appointed guardian for the unborn baby. Doctors believe it is the role of the obstetrical profession to police the behavior of the childbearing population and engineer uncritical compliance with the highly medicalized, mechanized labors and with increasing frequency, operative deliveries. This requires that organized medicine manipulate the political system so as to deny women any option outside of a tightly closed system which typifies independent midwifery as irresponsible and attempts to solve the "midwife problem" by making home birth socially unacceptable whenever and however they can.

|  |
| --- |
|  **Boston Medical and Surgical Journal, Feb. 23, 1911, page 261 -****Historical argument by obstetrical profession for the elimination of****an independent profession of midwifery:**  We believe it to be the duty and privilege of the obstetricians of our country  to safeguard the mother and child in the dangers of childbirth. The  **obstetricians** are the final authority to set the standard and lead the way to safety. They alone can properly educate the medical profession, the legislators and the public."    emphasis added |

In the most recent salvo, the financial resources and political influence of organized medicine have come together to promote a small, solitary and poorly-designed research project -- �*Outcomes of Planned Home Birth In Washington State*� by Pang et al, 2002*--* as definitive "proof" that merely planning a home birth (even though the baby is actually born in the hospital) is twice as dangerous as planning a hospital birth. In the 21st century, the vitriolic tone of the obstetrical profession is slightly more sophisticated, but in fact, their use of the Pang-Benedetti study is just another version of "laboring woman + midwife = dead babies". They want us to believe they have finally proved beyond all doubt that "Home birth Linked to More Infant Death" and "Twice as Many Babies Die in Home Births" and these statements should be uncritically accepted as the final word.

However, this is a false and misleading conclusion based on fatally flawed methods. It could only be arrived at by applying to the field of medical research the same type of self-serving "accounting" methods that have scandalized so many US corporations. In the  ignoble tradition of Arthur Anderson, Enron and the like,  representatives of organized medicine  **only counted data that promoted their biased agenda while ignoring massive amounts of evidence to the contrary**. Organized medicine also 'counts' on the public's lack of knowledge (and interest in) normal childbirth, statistical principles and the common habit of deferring to 'experts'  of all kinds, whether its the stock market or obstetrics.

|  |
| --- |
| *Outcomes of Planned Home Birth In Washington State*, **P.8** �The study has several limitations that are related to the reliance on birth certificate data. These include misclassifying various outcomes and co-variants. In addition, data were missing for some potential co-founders and effect modifiers.�  �**Several of the outcomes in this study may have been misclassified**, namely respiratory distress, requiring assisted ventilation for more than 30 minutes, prolonged labor and postpartum hemorrhage.� �  **misclassification might be greater in a home setting than in a hospital** � the magnitude and direction of any such bias cannot be predicted and so caution should be used when interpreting the results for these outcomes.   (**P**.**9)**    \*emphasis added) |

People naively assume that  *expert systems* will include unbiased '*experts*' who can be counted on to be intellectually honest. We think that someone "in the know" is watching the system and would report any wrong-doings. Clearly our assumptions of accountability were not true for those that manipulated corporate earnings or reassigned pedophile priests. Unfortunately our faith in the 'system' is also misplaced when it come to interventionist obstetrics and those that benefit from the manipulation of  its research. Obstetrics for healthy women is an expert system dominated by its own self interests, without adequate public accountability and little or no critical oversight by the media.

For women who are ill or have reproductive complications obstetrical care can be life-saving. No one is disputing that obvious fact. However these same medical and surgical interventions are often *life-threatening* when applied to healthy women with normal pregnancies. Instead of being a "value-added" service, adding the value of medical and surgical services above and beyond the traditional scope of midwifery, obstetrics for normal birth can easily become 'value subtracted', when formally healthy women or babies needlessly suffer iatrogenic complications. Interventionist obstetrics as applied to healthy women with normal pregnancies can introduce unnecessary and unnatural dangers and cause many of the problems it claims to prevent.

In order for obstetrical care to be as safe as midwifery care, physicians must teach, learn and utilize the physiological management of labor and birth for all healthy women, regardless of the setting for labor and delivery. This includes "patience with nature", the full-time presence of the caregiver during active labor, offering effective non-drug pain methods and "right use of gravity". Hospitals need to do their part to "normalize" normal labor and birth services by staffing hospital labor rooms with certified nurse-midwives who are supported in providing the physiological management as the standard for healthy women.

The problem with contemporary obstetrical care in the US is the uncritical acceptance of an unscientific method -- interventionist care for healthy women. It is a **hundred-year old failed experiment** that never honestly assessed its hypothesis. The unwillingness of the obstetrical community to come to terms with this fact perpetuates a form of obstetrical "Dark Ages" as the norm in the US, with ACOG functioning as a medical version of the Flat Earth Society. The issue before the public is not really the relative safety of home birth (a choice made by only 1% of women) but the relative risks of "standard" interventionist hospital obstetrics for healthy women, a choice made by  more than 90% of the childbearing population. It is hospital birth that is not "safe" and it is hospital birth that must be rehabilitated.

The important story, from an investigative journalist's point of view, is why organized medicine has embarked on a smear campaign focused on all forms of spontaneous labor and normal birth while promoting the ultimate unnatural, abnormal (and dangerous) form of delivery -- the "maternal choice" Cesarean. What are the hidden economic advantages and egocentric or professional agendas for doing this? How exactly are they 'cooking the books' so that a plethora of junk science can be spoon fed to an uncritical media and swallowed whole by an unsuspecting lay public?

At the center of the most recent firestorm is the �Outcomes of Planned Home Birth In Washington State�, published in August 2002 in the journal for the American College of Obstetricians and Gynecologist (ACOG). The study's  lead authors were perinatologist Jenny Pang and obstetrician Thomas Benedetti, a professor of obstetrics at the University of Washington. Dr Thomas Bennedetti has been a consultant and spokesman for the American College of Obstetricians and Gynecologists for many years. He is responsible for developing technical guidelines for the organization�s 40,000 members and educating other obstetricians in the finer points of ACOG policy. His work defines the �standard of care� in court for management of shoulder dystocia and other aspects of obstetrical practice.

**The Social Engineering of Consent**

Dr Benedetti is typical of what are known in medicine as "thought leaders " -- doctors who are usually on the facility of academic institutions and frequently publish "show case" studies that create a buzz in the newspapers and set the course of medical practice in a different direction. True to type, Dr Benedetti is on the peer review committee for the New England Journal of Medicine. It was the  [NEJM's who published the infamous study on VBAC inductions](http://docs.google.com/nejm01a_vbac_study_npr.htm) (also from the University of Washington). With the help of the Associated Press, the NEJM study was heavily promoted in newspapers and radio stories which, unfortunately, ignored the extreme dangers of induction (can increase uterine rupture rate by 15 times!), which was the legitimate point of the study. Instead the small risks of spontaneous labor were misrepresented and exaggerated and repeat Cesarean declared to be  �safest for the baby�. This social engineering of consent created an uncritical public acceptance of the notion that "once a cesarean, always a cesarean" was the new, better way.

In addition to his work with ACOG and NEJM, Dr Benedetti was also was central to the design for the Washington State study which curiously, did not include any input from the mothers and midwives who were its focus. Dr Benedetti was personally involved in presenting the study to the Reuters News Service at an ACOG conference in Los Angles last May, several months before it was published. Since unpublished research can't be read or critiqued by anyone, Dr Benedetti and Dr Pang became the official 'spin doctors' for the press, another opportunity to engineer public opinion. Their account of the study's merits and significance (both wrong!) were carried in newspapers all over the country, misleading the public and artificially creating a media "event" sympathetic to the interests of obstetricians and hospitals. This was achieved by manipulating the numbers so as to make home-based birth care appear uniquely dangerous while hospital birth was identified as twice as "safe". However the Reuters newspaper account of the study made no mention of the dramatically higher medical intervention and operative rate for women receiving hospital-based obstetrical care (35%), which is 3 to 6 times greater than planned home birth (4%). In spite of the frequent use of surgical deliveries in hospitals, there is no reduction at all in the rate of cerebral palsy for these babies. [7]

Eventually this disingenuous version of "doctors & hospitals save babies from the dangers of midwifery care" was picked up by the Associated Press Wire service and a second and third wave of stories followed. It was short on facts and long on disinformation. The headline in the Reuters� news service article (May 8, 2002) by Jacqueline Stenson cryptically encapsulated everyone�s worst fears, stating �**Home Births Linked to More Infant Deaths**�. In typical sensationalized newspaper style, the first sentence in the story followed with the chilling news that **�Twice as many infant deaths occurred during home births than with hospital deliveries�**. *For economy of phrase and dramatic impact, this newspaper style is hard to beat.*

|  |  |  |
| --- | --- | --- |
|  | **A brave and honest obstetrician ~ Beverly Miller, MD** ~ **on the topic of midwives and home-based birth services**  Email, ob-gyn-l@obgyn.net 1/31/97"all major studies EVER done (see the literature) support the fact that trained ... midwives (i.e., pass a licensure exam ... etc)  **have as good or better stats in out of hospital settings than OBs do in hospital**. The morbidity/mortality rates are lower in comparable pregnancies, the midwives frequently do a better job of risk reduction management, score higher in perceived quality of care (time element and rapport development count a lot here). I've heard physicians say that if one of the midwives they backed up lost a baby, they were convinced that they, too would have lost it.  .... Find a good midwife in your area and give her some support".  |  |

For the obstetrical profession, the anti-midwife/home birth propaganda campaign is a convenient way to distract the public from the dangers of obstetrical interventions and the ever-escalating operative delivery rate. It also provides ACOG with an opportunity to slime its most formidable "competition". They have a lot of incentive to do that. According to a long list of reputable sources, including the World Heath Organization and the Pew Charitable Trust, professional midwives are the most appropriate  -- that is, both safe and cost effective -- caregivers for women with normal pregnancies, for both in and out-of-hospital births. When care is provided by a professional midwife, in conjunction with appropriate access to medical services for complications, the consensus of the scientific literature is that community-based birth services are safe, cost-effective and reduce the operative delivery rate and associated complications. [8] When immediate and down-stream complications associated with the high (and still rising!) operative rate in planned hospital births are included in the "safety" equation (especially in regard to post-cesarean pregnancies) it is obvious that home-based or "domiciliary" midwifery services provides a protective form of care for healthy women and their babies.

**Flat Earth Obstetrics**

Compared to the excellent outcomes in Japan and of Europe, where midwifery is standard, our expensive obstetrical system ranks us in the bottom five countries for perinatal outcome, while having the third highest Cesarean section rate in the world. The Center of Disease Control (CDC) documented a steady annual increase every year since 1989 in four major obstetrical interventions -- electronic fetal monitoring, artificial rupture of membranes, and artificially induced and accelerated labors -- that are associated with increased operative delivery rate, especially Cesareans. [9]  The CDC recently documented the **highest Cesarean rate in our history** -- **24.4%** for the year 2001 -- and a 7% rise in just one year, accompanied by a  **20% fall** in VBAC [10] This also increases post-operative complications, emergency hysterectomies and triples maternal deaths by an equal measure. [11, 12]  Cesarean-born babies suffer triple the rate of asthma as adults. [13]

In spite of the extraordinary advances in medical science and technology in the last twenty years, our  **maternal mortality** rate has not fallen since 1982 and has actually gone up slightly in the last few years.  [14] The most frequent reasons for childbearing women to die in the US are hemorrhage and blood clots -- complications specifically associated with Cesarean surgery. [15,16,17,18] When all oversight and public accountability is removed from this "expert" medical system, what you get is dysfunctional obstetrics. In this dysfunctional system, 95% of normal births are subjected to routine medical and surgical interventions in high-tech hospital environments, which results in a predictable increase in preventable maternal mortality.

Not every obstetrician is fooled by all this foolishness. Here is what Dr Elaine Waetjen, an obstetrician at the University of California-Davis, had to say in a letter to the trade paper *Ob.Gyn.News* entitled "Elective Cesarean Revisited". She was addressing the question "Should we offer prophylactic C-section to prevent organ prolapse and incontinence?"

"The answer is that the evidence does not support this approach**.** Preventive strategies should cause no more harm than the disease or problem they are tying to prevent, Ideally, they should incorporate some kind of screening to identify people at risk. They should be cost effective and based on very good evidence of benefit. Elective C-section to preserve the pelvic floor function fails on all these measures.

"..... even if we assume that vaginal delivery is responsible for 85% of all cases [of pelvic organ dysfunction] ....we would have to do 23 C-sections to prevent one such surgery later in life"

�Cesarean surgery causes more maternal morbidity and mortality than vaginal birth. In the short term, C-Section doubles or **triples the risk of maternal death**, triples the risk for infection, hemorrhage and hysterectomy, increases the risk of serious blood clots 2 to 5 times and causes surgical injury in about 1% of operations.

In the long term, cesarean section increases the mother's risk of a placenta previa, accreta or percreta, uterine rupture, surgical injury, spontaneous abortions and ectopic pregnancies while decreasing fecundity. Babies delivered by cesarean have a higher risk of lung disorders and operative lacerations.� [19]

Dr Peter Berstein, MD, MPH, (clinical professor of obstetrics at Albert Einstein College of Medicine NYC) is another physician who has not been fool by the obstetrical claim that pelvic floor dysfunction and incontinence are just the unavoidable "collateral damage" of normal birth. He totally rejects the notion that the only way for women to avoid future incontinence is through the "prophylactic" cesarean. Dr. Berstein explains why medical management by physicians is so strongly associated with long term pelvis complications :

"...these adverse side effects may be more the result of how current obstetrics manages the second state of  labor. Use of episiotomy and forceps has been demonstrated to be associated with ... incontinence in numerous studies. Perhaps also vaginal delivery in the dorsal lithotomy position with encouragement from birth attendants to shorten the second stage with the Valsalva maneuver, as is commonly practiced in developed countries, contributes to the problem."

Regarding the ethics of performing of "maternal-choice" Cesareans and subsequent complications in a post Cesarean pregnancy, Dr Peter Berstein notes that:

"There may be no legal liability to the physician who performed the patient's first Cesarean when the patient winds up with a hysterectomy or worse, but that does not clear that physician of responsibility for performing a surgical procedure of unclear benefits upon a patient's request."

And finally in regard to the general situation of obstetrical over-treatment as the "norm":

"That women are seeking elective cesarean deliveries is probably more significant in that it indicates a failure of modern obstetrics and society at large in the sense that women may fear the experience of labor and birth attendants may fear the legal risks of allowing appropriate women to have a trial of labor.  ...  If elective cesarean delivery becomes an acceptable alternative,  *we may never to able to undo the practice*."  [20]

A recent survey of "regularly performed" obstetrical practices was conducted by the Maternity Center Association of New York City (MCA), a national organization dedicated to improving maternity care since 1918.  The data focused on childbirth in the last 24 months among healthy women with term pregnancies and documented that �women who gave birth vaginally were subjected to high rates of interventions and medical practices with **established** or potential **adverse effects**.�  [21] The researchers stated that: ��*there were virtually*  ***no*** *�natural childbirths� among the mothers we surveyed.  Less then 1% of mothers gave birth without at least one of these interventions, and almost all of these came from the very small group (also less then 1%) of home births in our sample.��*[22]

The *Listening to Mothers*' survey revealed that 93% of hospitalized women were exposed to continuous electronic fetal monitoring (associated with increased Cesarean sections rates *without* improvement in perinatal mortality), 86% had IVs while being prohibited from drinking or eating, 74% were required to give birth lying on their back, 71% were immobilized / confined to bed / not permitted to walk during labor, 67% had artificial rupture of membranes, 63% had labors induced or accelerated with artificial oxytocin (Pitocin), 63% had epidural anesthesia,  **58% had a gloved hand inserted into their uterus after birth**, 52% had bladder catheterizations (causes an increase in bladder and kidney infections), 35% had episiotomies, 24% had cesarean surgery (2-4 times higher rate of maternal mortality, abnormal placentation/ emergency hysterectomy in subsequent pregnancy, *without any reduction in cerebral palsy rates*) and 11% of babies were delivered via forceps or vacuum extraction, for a total of 35% operative delivery, *not* counting episiotomies, which would raise the rate to 70%.

Please note these statistics are for healthy women at term with normal pregnancies. Intervention rates would be much higher for women with premature labor, multiple pregnancies or medical complications.

**Absence of Due Diligence**

The routine practice of contemporary obstetrics, as it applies to normal childbearing by healthy women, does not meet its burden of proof for even the least level of ethical practice � �primum non nocere� or �in the first place, do no harm�. It also does not meet even the minimum standard of truly informed consent. We live in an era of lavish scientific literacy, including Internet access to books and data bases, CDs and on-line user groups. A diligent physician could and should know as much about the immediate and downstream complications of obstetrical interventions as the average lay reader of scientific literature and obstetrical internet sites.

**"There is no alibi for not knowing what is known"**

**J. Rovinsky, MD ~ foreword from *Davis Gynecology & Obstetrics* ~ 1966 obstetrical textbook**

I would go so far as to assert that it represents a **lack of due diligence for obstetricians to be so ignorant of their own profession,** most especiallyin regard to the  *consequences of major interventions* such as labor induction, forceps and Cesarean surgery. Here is an example of the scientific literature on the topic of cesareans complications available on-line to obstetrician and lay reader alike:

### **Ob.Gyn.News Dec 15 2002 \* Volume 37 \* Number 24**

**Last 50 Years Show 10-Fold Rise in Placenta Accreta ~ Behind 50% of emergency hysterectomies**

�Placenta accreta is a growing cause of postpartum hemorrhage and an increasing cause of **emergency hysterectomy**, according to Dr. Gary Dildy III. "The incidence of placenta accreta is increasing, and it's thought this may have to do with the **increasing rate of cesarean sections** since the 1960s," he said at the annual meeting of District V of the American College of Obstetricians and Gynecologists.� (Emphasis added)

#### Ob.Gyn.News March 1, 2001 Vol 36, No 5

�The rise in cesarean rate over the last several years may portend an increase in the incidence of placenta accreta�, Dr Richard Porreco warned, �I think that with the cesarean rate what it is we are creating a potentially very great problem down stream�.   �The **maternal mortality rate with placenta accreta is 7%**. Even when physician are prepared and well equipped the condition can be extremely dangerous�, Dr Porreco said. �at his institution a woman who had undergone three previous cesareans was diagnosed with a percreta �.(she) underwent an abdominal hysterectomy and bladder resection.  --- the **patient ended up going into cardiac arrest** during the procedure and had post operative complications that kept her in the hospital for 20 days. (Emphasis added)

**Ob.Gyn.News Sept 15, 2001  Vol 36, No 18**

�In one study, the rate of placenta accreta in patients with *no prior* C-section was 5%, **25%** with one prior CS, and **50%** with two or more prior Cesareans.    Furthermore, � the patient has an **80%** likelihood of **hysterectomy** following delivery. Prepare for a 4-hour surgery with an average 4 liter blood loss, You may need to use up to **20 units** of packed red cells and be prepared for **ureteral injuries** which occur in 2%-3% of patients.� (emphasis added)

Since obstetricians also provide normal maternity care to healthy women (70% of the patient population), they also have an obligation to be knowledgeable and skilled in the "normal" or physiological management of spontaneous labor and birth, including "patience with nature" and the "right use of gravity". Scientific sources establishing the benefit and the methods of physiological management are likewise readily available to physicians who are diligent. In spite of glaring deficiencies in both these vital areas, the obstetrical profession is quick to use the lay press as a forum to promote the ever increasing medicalization and mechanization of normal birth, full speed ahead, damn the torpedoes, damn the expense and damn the irrefutable evidence of iatrogenic complications.

For the last hundred years no one has held the medical community to the standard of transparency and forthrightness appropriate for a PhD in a scientific discipline � factually correct and scientifically valid information communicated in a public forum, *unless such statements are identified as merely a personal or political opinion*.

The problem is that physicians are the natural spokespersons for the scientific discipline of medicine, a circumstance that places a societal burden of candor and accuracy on doctors by virtue of their advanced education. The obligation intrinsic in this education creates a higher standard of conduct than mere recitation of personal preference or professional self-promotion. The very fact that physicians are the holder of a doctorate (a PhD) in the science of medicine gives the public *every good reason to believe* that all informative public statements made by physicians about matters of health, safety and medical care are *unbiased, scientifically-based and factually correct*. This would include the duty to communicate only scientifically valid information in a public forum unless such statements are identified as merely a personal opinion.

Simultaneously with the propensity of our an uncritical press to so generously hype up �medical miracles� relative to childbearing, there is what amounts to a media black-out of accurate and reliable information made available to the public on the normalcy of childbirth. In spite of laudable improvements in maternal health and safety over the course of the last century, our culture seems to be controlled by an exaggerated and debilitating fear about childbearing, combined with a dearth of useful information about normal birth. What is conspicuously absent in the public arena is an examination of the risks of routine medicalization, a realistic appraisal of its cost-benefit ratio, unbiased facts on the relative safety of different birth settings and the universal efficacy of the midwifery model of care as provided by doctors and midwives working side by side to serve for healthy women and their newborns.

For a variety of reasons, the American public, the American press, agencies of state and federal governments and the courts have never required that the obstetrical profession�s incredible claims of the last 100 years and the drastic and dangerous treatments routinely applied to healthy women in hospitals through out American be proven safe and effective or at the very least, that they do no harm or at the very, very very least, that the known risks are communicated to the childbearing family and freely chosen by them with true fully informed consent. Were the obstetrical profession to attempt to advertise the present configuration of interventionist maternity care on broadcast media, they would not able to provide the Federal Trade Commission with the  �reasonable proof� of these claims required by law. Obstetricians cannot meet this burden of proof because it simply does not exist.

But more important than whether the FTC would let ACOG runs adds on TV for the agra-birth business  is the larger question of how this medical monopoly impacts society. If we were to have another national emergency on the order of the 9/11 attack, such as a bio-terrorism or a �dirty bomb�, one must question whether it would be appropriate to take up 20% of our entire medical and surgical resources to provide maternity care to healthy mothers and normal babies while our loved one suffer and die unattended in the hospital parking lot? Do we want to hospitalize healthy women and normal babies under such circumstances, exposing them to small pox, anthrax or nerve gas? Is it wise and cost-effective, is it kind to women and babies to a have a national maternity care system in which doctors only know how to numb mothers up with drugs and anesthesia and then suck, pluck or cut the baby out with instruments or surgery, tripling the number of mothers dying in "childbirth' and exposing them to all the other down-stream complications such as incontinence?

### A Closer Look  - More Light, Less Heat

The great majority of studies of healthy women who choose home-based birth services under the care of an experienced birth attendant document outcomes of equal or greater safety for their unborn and newborn babies. These studies consistently identify a perinatal mortality rate in all birth settings (home, hospital and independent birth centers) of approximately 2 per 1000 live births (excluding prematurity and congenital anomalies). [23, 24, 25, 26 ]. Using this criteria the Pang Benedetti study identified a neonatal mortality rate for home birth to be 1.95 per 1000. In those cases of neonatal morbidity or mortality associated with �planned home birth�, the vast majority of mothers included in this study were transferred to the hospital during labor. While this statistical data was not provided in the Pang Benedetti study, the pre-delivery hospitalization rate was 88% in the other studies of planned home births done in Washington State during the same time frame (1989-94). In addition to the already small statistical difference between the two groups, the study identified 5 neonatal deaths (0**.**82 per 1000) in the planned home birth group that were the result of congenital cardiac disease and 3 babies (0**.**49 per 1000) who died of other major congenital anomalies.

One of the few studies to note an increased perinatal mortality rate in home-born babies is an Australian study [27] that documented a perinatal loss 1.6 higher but *only for pregnancies that were already identified as higher risk or included a complication --* twins, breech, compromised post-date pregnancies and thick meconium in the amniotic fluid during labor*.* For the vast majority of circumstances, these factors would automatically risk the mother out for home birth. However, the author's introduction was particularly insightful and put this topic in proper perspective:

"Despite decades of political and academic debate, the relative merits of home versus hospital birth remains unproven. This is likely to remain so. Comparisons that are sufficiently unbiased and large enough to address crucial safety issues are unlikely to be forthcoming [1,2]. Although home and hospital offer different benefits for birth, neither has �standard care� characteristics. In fact  **the range from safe to unsafe practice may be winder within each location that it is between** them. This may be a more pivotal concern than attempting to quantify the theoretical differences attributable to place of birth." emphasis added

### **�The Safety of Childbirth Alternatives� -- 1999 study by Stanford PhD -- 47 times bigger and better designed**

Dozens of large, well-designed studies refute the conclusion drawn by the authors of the Washington Sate study. However, the best example by virtue of being both recent and 47 times more statistically �powerful� (with a very large and well-designed database) is a 1999 study by a Stanford PhD, Dr. Peter Schlenzka (pronounced �Shaa lens Ka�). Dr. Schlenzka also conducted a thorough review of scientific literature with a bibliography of 189 references and over 50 pages of literature review on topics such as the medicalization of childbirth, the shift from home to hospital birth and the risks of obstetric interventions as compared with the physiological approaches. The data produced by Dr Schlenzka�s are in sharp contrast to those in the Washington study and in fact, **arrive at an exactly opposite conclusion**.

Dr. Schlenzka's research is the largest comparative study ever done on the safety of these contrasting birth management strategies for normal maternity care. It is the theory of the obstetrical professions that obstetrical interventions in normal birth improved outcome and that hospitals birth is "safer" since hospital can provide interventions either prophylactically or immediately in an emergency. While the Pang and Benedetti study only examined 20,000 births certificates (without a chart review of any kind), Dr. Schlenzka sifted through more than a million California birth certificates and also matched hospital discharge summaries for  *both mother and baby* in order to put this medical hypothesis to the test of scientific scrutiny.

*The Safety of Childbirth Alternatives* is a research project that Dr. Benedetti himself is familiar with as Dr. Benedetti lectured at Stanford University Hospital �Grand Rounds� on the management of shoulder dystocia during the time Peter Schlenzka was doing this research. The chief of neonatology for the obstetrical department of Stanford University Hospital was directly assisting Dr. Schlenzka in setting up a complex mainframe data based used to analyze the information from 3 separate sources on birth outcomes. In many ways, the Pang-Benedetti study seems to be designed specifically to refute the conclusions arrived at by Dr. Schlenzka�s work. In the letter from ACOG to the California Medical Board, a point was made of the "peer reviewed" aspect of the Pang study. While a PhD thesis is reviewed by many professors and dissertation advisors and thus held to a most rigorous scientific standard, it is not technically considered to be "peer reviewed". However, the fact that Dr. Schlenzka is not an obstetrician also does not make the information wrong or his research  methods invalid.

After careful matching of all appropriate data, Schlenzka examined perinatal outcomes of 816,000 births, comparing low risk births inside and outside the hospital and high-risk births both in and out of the hospital. His findings clearly show that physiological management and the obstetric approach (i.e., interventionist management) both produce the same perinatal mortality outcomes for low-risk and high-risk births in both setting � home and hospital. For low-risk women who opt for out-of hospital settings Dr. Schlenzka was able to document a slightly better (though not statistically significant) outcome in terms of lower perinatal mortality. After analyzing all of his data on perinatal outcomes, ( p. 153) Schlenzka concluded:

�Under  **no**  circumstances do the California data for 1989 and 1990 allow the obstetric profession to uphold the claim that for the large majority of low-risk women hospital birth is "safer" with respect to perinatal mortality.�

In his abstract, Schlenzka concludes (intro pages iv-v):

�Given no differences in perinatal mortality, it must be noted that the natural approach shows significant advantages with respect to lower maternity care costs as well as reduced mortality and morbidity from unnecessary cesareans and other obstetric interventions, and significant benefits from avoiding negative long-term consequences from unnecessary obstetric interventions and procedures. These advantages of the natural approach are of such a large order of magnitude as **to raise serious doubts concerning the appropriateness of conventional "obstetric" treatment for low-risk childbirth.** \*emphasis added

Finally, he reviews research suggesting that a wide variety of social ills linked to birth trauma, such as lack of bonding between the mother and infant, involve a great economic and social cost to society and that a less interventive birth model would reduce these ills. From this analysis, Schlenzka concludes that the **"apparent disadvantages of the obstetric approach have such large order of magnitude, that in any clinical trial it would be considered unethical to continue with the obstetric 'treatment' "** (p. 175).

|  |
| --- |
|  **email from a midwife-unfriendly obstetrician** on profession discussion group, ob-gyn-l@obgyn.net 1/17/97."...as an Obstetrician, I have learned that when things are left to themselves things usually turn out ok. In essence, we represent expensive "insurance policies" to those giving birth in a hospital under our care. ... how could we ever get enough numbers to compare outcomes with ... midwives, given the  **infrequent** ... complication rate of childbirth, especially seemingly low risk ... ones". ~  |

Manipulating the Media -- All that glitters is not gold....

I have read hundreds of scientific studies on medical topics and upwards of 50 well-designed midwifery and home birth comparison studies from around the world. Based on that body of research as the bench mark for good science, it is my opinion that the Pang Benedetti study comes within a hair�s breath of being junk science.

To put the scientific methodologies of this study in perspective it is useful to note that the total number of births in this study was only 16,726 (out of approximately 4 million each year) while the total number of neonatal deaths (for both home and hospital groups) was only 38. This small number is further reduced when congenital anomalies, which were responsible for one half the loses (19 babies) are subtracted, leaving only 19 deaths -- 7 in the hospital cohort (0**.**7 per 1,000) and 12 (1**.**95 per 1,000) in the home birth group -- from theoretically 'preventable' causes. However, no chart review of these cases was undertaken by the researchers, even though this extremely small number means that one or two cases would tip the scale one way or the other. It must be remembered that "twice as many" of a very small number is still a very small number.

Each and every one of those losses was tragic to each individual family. But from the standpoint of statistical analysis, the frequency of neonatal death was still a statistically rare event. This makes it hard to distinguish the unusual or "freak" accident from mortality directed *attributed to a substandard* form of care. One of the observations in *The Safety of Childbirth Alternatives* (by Dr Schlenzka) is that perinatal mortality is not a very useful measure of relative safety of either birth methods or location, since it is both rare and generally distributed equally in all three settings -- home, hospital and birth centers. The Pang Benedetti study seems to me to be a prime example of this observation.

**~ The Politicalization of the Scientific Method:** Aside from the diminutive size of this research, the major complaint that midwives and consumer groups have with the study is not the research itself so much as the over-reaching nature of its conclusions and the misleading uses to which it is being put by representatives of the American College of Obstetricians and Gynecologists.

An example of ACOG's politicalization of the study was the notice posted on the ACOG web site last August, which used the raw numbers (i.e., total birth certificates pulled) instead of the actual numbers (those that met the study's comparison criteria), which was smaller by five thousand. Equally telling, they used the incendiary language of the newspaper articles -- "Twice as many babies die in home birth" instead of the academic language of the actual study. Did they feel a need to pump up the numbers and employ rhetoric to make it look more formidable and definitive? In December, ACOG wrote a letter to the Medical Board of California citing this solitary study as irrefutable "proof" that planned home birth is inherently "unsafe" and called for regulations that would eliminate all home-based birth services by licensed midwives.[31] To make sure the medical board got the point, ACOG included a complete copy of the study with their letter which said.

"The Washington State pilot program was reviewed in the peer reviewed journal "Obstetrics and Gynecology" (August 2002, Vl100, No 2 pages 253-259). The objective of the study was "To determine whether there was a difference with regard to certain adverse infant outcomes (neonatal death, low Apgar score, need for ventilator support) and maternal outcomes (prolonged labor, postpartum bleeding). A copy of that article is attached for your information". Dec 20, 2002, James A Macer, Chair, ACOG, District IX

The letter summarized the results of the study, listing as irrefutable scientific fact beyond all question that planning a home-based is associated with twice an many low 5 minute Apgar scores, greater proportion of respiratory distress at delivery, a trend towards "prolonged labor" and increased rate of postpartum hemorrhages in first-time mothers and a "risk of neonatal death (i.e., within the first 7 days), ...almost twice as high", identifying the cause of increased mortality to be associated with birth defects and respiratory distress.

In the months since this show-case study was published, many community midwives and the families they serve have reported a sudden and negative shift by physicians. Home birth families report conversions with formally friendly (or at least neutral) doctors in which the doctor used the words "baby die" aggressively and repeatedly, and demanded to know  "How will you feel when your baby is permanently brain damaged because you wanted a home birth?"  In one instance, the police were called when a home birth transfer family (after the safe and uneventful hospital birth of their baby) asked to be discharged soon after the birth. An armed and uniformed police officer sat in a chair outside the labor room door until the pediatrician decided he'd made his point and permitted them to take their new baby and go home to their three older children. Community midwives and home birth families now find themselves thought of in the same category as terrorist groups as if, by our association with home-based midwifery care, we are irresponsible at best and at worst reprehensible killers of innocent babies.

**~ Methodological Problems:** The minor but also critical complaint is the many serious methodological flaws in the study. It is narrowly-drawn with a hospital-centric focus, defining most of the 'adverse' outcomes by arbitrary medical time frames and then only counting those events that occurred during the period of time that a maternity patient would be hospitalized.

Even more important, the same narrowly drawn criteria for ' adverse events' also left out the vast majority of serious morbidity and mortality for the childbearing women that result from the procedure-intensive interventions of "planned" hospital birth. The high level of interventions during labor and the many long-term complications of those interventions were never factored into their notion of "safety".  While interventionist care applies to virtually 100% hospitalized women with a normal pregnancy, the study did not account for the complications caused by upstream interventions such as Pitocin-accelerated labors, epidural anesthesia, episiotomy, forceps and vacuum extraction nor did they account for downstream complications � operative, post-op and long term complications in post-cesarean pregnancies including placenta previas, precretas, emergency hysterectomies, blood transfusions, or uterine ruptures in subsequent pregnancies.

One hospital parameter cited as an "adverse" effect of home birth were so-called "prolonged" labors. But exactly how was "prolonged" labor determined, by whose standards and what measures? When does the clock start? Is the prodromal or latent stage of labor included in that statistic or only active labor, after 4 centimeters of dilatation? Is the medical custom of giving 63% of hospitalized women Pitocin to speed up labor factored in or out of the statistical pool? Are allowances made for the plain fact that it is both unwise and illegal for domiciliary practitioners to artificially induce or accelerate labor at home? Is there any creditable evidence to suggest that shorter labors are themselves safer (especially when Pitocin-induced) or that longer ones without signs of maternal or fetal stress are dangerous? While there are no answers to these queries, the authors assure us that midwives are doing it wrong based on the idea that the 'right' length of labor is whatever happens in hospitals.

The same type of conversation applies to the study's findings on postpartum hemorrhage, which they claim to be significantly increased in first time mothers who delivered at home. Since this data came primarily from birth certificates, it also has no uniform definition or method of collection. We don't know if hospital practitioners define heavy bleeding as a 'hemorrhage' more or less often than community midwives. Did they measure blood loss or just 'eyeball' it or was the definition based on serious maternal symptoms requiring treatment? Blood loss during a Cesarean section is 'normally' extensive -- twice that of what is generally used as the definition for PP hemorrhage but since that occurs during the delivery (instead of afterwards) was that counted in or left out of the study's data on excessive blood loss?

Also there is the issue "active management" of third stage, which is a policy used in most institutions of giving every mother a prophylactic injection of Pitocin immediate after the baby is born, whether or not there is reason to expect she might bleed excessively. Many studies have documented a lower rate of postpartum hemorrhage with "active management". However, there are also occasional complications caused by routine use of Pitocin and the majority of women giving birth at home do not want "routine" drugs use. The majority of community midwives in the US do not use "active" management unless there are identified risk factors. Is it possible that the data in the study has far more to do with active versus physiological management  than the location of the birth?

Another criteria chosen by the authors that disadvantages home-based midwifery or at best, muddies the water, was identifying neonatal ventilation over 30 minutes as a marker for the most seriously sick babies, and indirectly, the assumption that this confirmed the dangers of community-based midwifery. Absolutely for sure the need for positive pressure ventilation is very serious event and indicates a real emergency. Whether or not it has serious on-going consequences depends on what the diagnosis is, which is about 70-30 between a temporary illness and long complications. However, what isn't immediately apparent, is that virtually 100% of home-born babies that need to be resuscitated at birth will be ventilated for a minimum of 30-minutes while being transport by ambulance, admitted to the hospital, evaluated by the perinatologist and a provisional diagnose arrived at before the ventilation process can be assessed and discontinued. This parameter would be much more useful as a marker for quality of care if applied to babies who demonstrate an on-going complication such as meconium aspiration or oxygen deprivation requiring ventilation past the first 48 hours.

These are just a few of the methodological flaws and statistical glitches that keep us from being able to have confidence in the conclusions ascribed to home-based midwifery care. In fact, it seems that the study functions best as fodder for propaganda -- raw data that can be easily manipulated into ammunition for the disinformation campaign against independent midwifery. As if they took pointers from Peter Schlenzka's work, the authors mixed and matched their criteria to include neonatal mortality *and* Apgar scores, assisted ventilation, respiratory distress, prolonged labor and PP hemorrhage -- certainly can't accuse them of ONLY identifying perinatal mortality as the water-shed criteria.

But in spite of the often repeated disclaimer by the authors that their paper was narrowly drawn and did not address the wider issues of long-term safety or cost-effectiveness, ACOG has missed no opportunity to misrepresent and distort this research for its own purposes. One can only assume that all this slight of hand is a desperate attempt to distract us from asking the really important questions -- is interventionist hospital care **safe** for healthy women with normal pregnancies? Is it scientific and evidence-based? Is it cost-effective? Does it meet the practical needs (emotional and developmental as well as long term safety) of mothers and babies?

**A Closer Look**

While it does not undo the "yellow journalism" associated with ACOG's propaganda efforts, it is useful to understand the technical problems that preclude the Pang-Benedetti study from providing any definitive answers to the issue of relative "safety". The following serious flaws which occurred because its authors:

* Substituted "educated guesses" for factual data
* Used "soft" data to arrive at "hard" conclusions
* Skimmed off the operative complications from the hospital group  **before** calculating the complication rate for the hospital cohort
* Came to global conclusions based on extremely narrow criteria that included (by their own admission) missing and misclassified data
* Ignored an astronomical rate of upstream medical interventions and "procedure-intensive" care (such as being kept in bed, Pitocin-accelerated labors, narcotic use, epidurals, episiotomies) associated with "planned hospital birth"
* Ignored all the subsequent down-stream complications associated with the high operative rate in planned hospital births -- infection, blood transfusions, hysterectomies, admission of babies to neonatal intensive care -- and the long-term complications, especially incontinence following forceps use and those in post-cesarean women -- placenta previas, percretas and abruptions, uterine rupture  with neonatal death or neurological damage in subsequent labors
* Obviously efficacy was  not part of their equation

        A[**Comprehensive Review**](http://docs.google.com/ACOG%20%20Hm%20Brth%20Study%20Aug%2002.htm) of Pang-Benedetti Study is available on the College of Midwives' web site

~ **Mushy Numbers:** The first manipulation was the mushy way data was included or excluded. For example, the authors included pregnancies at 34 weeks, which is 6 weeks before the term of pregnancy. This provided sufficient numbers to achieve "statistical significance" in the ratio of results in the two cohorts. However, midwives don't provide home-based care to women having premature babies *and* it is a dubious if not invalid method to artificially force statistical "significance" this way. Many of the study�s conclusions were based on assumptions or "soft" data that, by the authors� own admission, included missing and misclassified data. For example, data for �assisted ventilation� was missing in 1,170 charts in the hospital cohort of 9,423 (12% of the total), while only 160 (0**.**3%) of data sets were missing in the planned home birth cohort of 5,983. A 1996 study using Washington State birth registry data already reported that women choosing the care of licensed midwives are less likely to utilized genetic testing and/or to terminate a pregnancy if a birth defect is diagnosed, but no less likely to carry a fetus that has an organic or chromosomal anomalies. For example, 40% of the neonatal mortalities (8 of the 20) in the home birth cohort of 6,133 (incl. 279 hospital deliveries) were the result of birth defects. Choices made by this population of women are the determining factor here and not the intended place of birth.

|  |
| --- |
| *Outcomes of Planned Home Birth In Washington State,* **p.2** �Because Washington State birth certificates do  **not** identify which home births are planned,  **we defined**  planned home birth as those singleton newborns of at least 34 weeks gestation who were delivered at home and who had a midwife, nurse or physician listed as either attendant or certifier on the birth certificate.�   |

**~ Counting Invisible Data:**  The second major manipulation in the Pang-Benedetti study was a fundamental flaw in the premise of the research combined with its core method. It purports to be a study based on the relative safety of **intended** place of birth but it was conducted in a state that does  **not** track that information. The birth registry in Washington State does not record "intended" place of birth**.** It should have never used the words "*Planned Home Birth*" in its title because this characteristic could not be accurately quantified. Intention can only be identified by the professional attendant and without that critical distinction, all you have are 'by guess and by golly' assumptions. By contrast, a respected Australian study appropriately defines " planned home birth" as a birth that �at the onset of labor was intended to occur at home�.

Since Washington State doesn�t record "planned" place of birth, the authors included any baby born outside of the hospital at or after 34 weeks whose birth certificate was signed by a nurse, doctor (7 1/2%) or midwife as "planned" home birth. This process did not control for absent or inadequate prenatal care or establish that the signator on the birth certificate was professionally trained, licensed and experienced as a provider of domiciliary midwifery care. Community-based birth services are quite different from hospital care. Training in physiological management in a domiciliary setting is not a normal part of medical or nursing school programs. Some home birth studies that include MD birth attendants noted an  *increased rate* of serious complications and perinatal mortality as physicians are more likely to try to manage complicated births at home than the typical midwife. These cases make clear that it is the services and equipment of the modern hospital even more than the skills of the doctor that are necessary when serious complications arise.

The authors of this study also did not understand the idea of �planned� home birth from the perspective of the practitioner. Midwives do not arrive at that determination until we have personally evaluated the mother *after active labor has begun*. This same protocol and the same limitations apply to community hospitals. They also do not �plan� to provide intrapartum care to women with obstetrical complications and so routinely evaluate the mother at the onset of labor and transfer those found to be at high risk. So also for midwives. However community midwives and community hospitals still have �unplanned births� occur before transport can be accomplished and both also have transfers of care, which I consider an indicator of success and not a failure.

|  |
| --- |
| *Outcomes of Planned Home Birth In Washington State,* **(p.3)**  �In addition, singleton newborns of at least 34 weeks who were born after transfer from home to a medical facility were considered to be planned home births if there birth certificates indicated that delivery was initially attempted at home by a health care professional.�   |

Obviously it is  *not an "intended" home birth* when the midwife assesses the mother at the onset of active labor and, detecting a potential or actual problem (bleeding, meconium, heart rate irregularities, etc), recommends immediate hospitalization. It is  *not an intended home birth* when a premature baby delivers precipitously as the midwife walks in the front door. However, the Pang study did not/could not make this distinction because the Washington State birth registry does not identify the intended place of birth or the circumstances of hospital transfer. Based on assumptions instead of verifiable facts, the study counts both of these circumstances as "planned" home births, even though one of the two deliveries did not even occur at home.

One wonders why anyone would plan to use birth certificate data from a state that does not collect information on �intended� place of birth as the foundation for a study on birth outcomes relative to "intended" place of birth? (If you are confused it is because it is confusing.) Since when does an "educated guess" based on a series of unsupported assumptions replace accurate data, especially when talking about such a small data set -- 12 neonatal deaths (excluding congenital anomalies) out of 6,133 birth? That is a ratio of 6,133 to 0**.**02 or 2/10th of one percent.

**~ Leveraging Birth Defects to Advantage:** One must assume that the authors, all on the facility of the University of Washington, were aware of and took note of observations made by the previous (1996) Washington State study on planned home birth. This earlier study identified an unusual number of neonatal deaths from congenital malformations in the home birth cohort. In the sometimes crazy world of perinatal statistics, the death of "defective" fetuses due to therapeutic abortions does not count against the practitioner's record. It is a little acknowledged fact that one of the major reasons for our "improved" perinatal outcomes in the last 20 years has not been scientific improvements in labor and birth care -- especially ultrasound and use of continuous electronic fetal monitoring -- as assumed by the press and lay public. Rather it is the combination of genetic testing and legally available abortion, which removes sick babies from the perinatal statistics pool before they are born. However, families choosing community-based midwifery often do not **utilize genetic testing and/or they choose *not* to abort babies with birth defects**. This has nothing to do with the type of care they receive or the planned location for birth.

The study design made it appear as if neonatal deaths from birth defects were the result of the mother's "plan" to give birth at home and that if these same women had instead "planned" a hospital birth, twice as many of their babies would have lived. Five of the eight deaths from birth defects in the planned home cohort were the result of cardiac anomalies. It is true that babies with treatable types of congenital heart disease are easier to manage when they are born in a large hospital with a pediatric heart specialist immediately present. However, we have no way to know if these 5 babies had the kind of heart defects treatable with surgery (short of heart transplant!) and would have survived if only they had been born in a hospital. We don't even know if those babies were among the 279 hospital transfers and actually were born in the hospital before succumbing to a fatal form of heart defect.

According to the study authors, universal hospitalization for normal birth will prevent neonatal deaths from respiratory distress, and most birth defects, especially cardiac anomalies. However this would require all pregnant women to have extensive genetic testing (without consent if necessary and acknowledging that some tests results will turn out to be wrong) and to require that all deliveries occur only in big medical centers with 24-7 coverage by pediatric cardiologists. In many geographical areas, this would mean closing the maternity units of small and medium sized community hospitals and then requiring laboring women to either drive long distances in labor or be induced to avoid having their baby in the car on the way to the hospital. Ultimately this would just exchange one source of mortality and morbidity for another and deprive us of community health services.

**~ Selective Selection/Creative Accounting:**  The way data was collected leaves one to wonder if the study design was not driven by the need arrive at the predetermined conclusion that hospital birth was better. The problem is that the numbers do not add up. Statistically speaking, a hospital cohort of 10,593 healthy women can be expected to include approximately 10% operative deliveries (forceps and vacuum extraction) 10% of primary Cesareans, another 10% of elective repeat Cesareans and about 5% of vaginal birth after Cesarean mothers. That is approximately 3,500 operative or post-cesareans deliveries. Each of these surgical categories is well established to have significantly increased rates of complication, including maternal hemorrhage and neonatal respiratory distress.

For example, intra-operative blood loss for Cesareans is approximately 1,000 mls, which is twice the amount of blood loss that defines postpartum hemorrhage (>500 mls). It should be noted that the authors only identified "postpartum" hemorrhage as criteria for the study, which could mean they did count intra-operative bleeding/hemorrhage as a complication in the hospital cohort. Neonatal respiratory distress is also associated with medical and surgical procedures, especially use of force (forceps and vacuum extraction) and anesthesia necessary for Cesarean and other operative deliveries. However, the incredibly low rate of postpartum bleeding reported for the hospital cohort and the zero rate of respiratory distress mortality makes it appears that this 35% of operative, cesarean and post-cesarean labors and their complications were not accounted for.

Unless and until evidence to the contrary is provided by the authors, it must be assumed that they excluded operative deliveries from the hospital cohort. This is the only logical explanation for a neonatal mortality rate in the hospital cohort of only 0**.**7 per 1,000, without a single neonatal death from respiratory distress and a remarkably *lower postpartum hemorrhage* for new mothers.  Hospital birth, even for healthy mothers, results in a 30 percent operative delivery rate --  forceps / vacuum extraction / Cesarean section -- compared to only 5% rate for planned home births. You can't slice and dice that many childbearing women without spilling a lot of blood and contributing to at least one fatal respiratory distress.  **By isolating intra-operative and post operative complications from the data pool, the remaining outcomes would be incredibly enhanced.** None the less, it is not a proper method to arrive at global conclusions on relative safety. The difference between the two -- 25% -- should have been included in the data set for institutional care. Instead, the hospital cohort used by the study consists of only spontaneous vaginal birth.

It seems that the Washington State study arrives at its supposedly superior numbers for hospital birth by skimming off the approximately 30% of surgical deliveries and associated complications **before** figuring the �complication� rate. In other words, it takes its data down stream. By not counting the inevitable complications (infection, maternal hemorrhage, depressed baby, intra-cranial bleeding, etc) associated with these surgical procedures, the authors came very close to being able to claim perfection -- less than one neonatal death per 1000 (actually 0**.**75**:**1,000). The CEOs of several infamous corporations would instantly recognize these 'creative' accounting strategy -- ignore negative numbers, count the positives four or five times and sweep everything embarrassing under the rug.

Irrespective of these many machinations, the half dozen "fatal" methodological flaws renders the study's conclusions invalid for any purpose other than documenting the lower rate of genetic testing by families who choose community based birth services with a licensed midwife. With this data they could design public services announcements on informed choice and potential benefits of genetic testing aimed at this small subgroup of parents-to-be, so they could plan to give birth to any baby diagnosed with a significant congenital anomaly at a major medical center with plenty of surgical specialists on hand.

~ But regardless of the exact numbers used, the bottom line is that the neonatal mortality rate for home-based care is generally excellent -- determined by most studies to be around 2 per 1,000, excluding congenital anomalies (P. Schlenzka). Using that criteria, even the Pang study, warts and all, only recorded a rate of 1.95 per 1,000, with a total Cesarean / operative rate of less than 4% for "planned home birth". The difference between the two cohorts was slightly more than one per 1,000. However this 1/10 of one percent �advantage� in the hospital cohort came with the consider cost (economic and otherwise) of an approximately 30% operative rate (7 � times higher than the planned home birth cohort). Were immediate and down-stream complications associated with the normally high operative rate in planned hospital births, especially those in post-cesarean women, factored into the authors� definition of �relative safety�, then home-based birth services would have to be considered a protective form of care for the babies of healthy women.

The real issue here is not the whether home birth is safe but whether hospital birth for healthy women, with its 30% operative rate, can be considered worth the many well-known risks?

**The Last Word --**

As usual, the issue of �home birth� is a really red herring -- that is, a topic that distracts us from the more important and more obvious issue -- the quality of care received by the 99% of women who choose to labor and give birth in hospitals or, due to medical circumstances, must labor and give birth in hospitals. The US spends more money on maternity services than *any other country in the world*, yet we have next to the lowest vaginal birth rate and are 22nd (third from the bottom) in perinatal mortality out of 25 developed countries. Shame on us. This is a very subtle or "soft" form of institutionalized violence against women and babies. [29] In addition to the outrageous cost and other inefficiencies, there are multiple problems with the current interventionist system that beg for correction. We pray that the American College of Obstetricians and Gynecologists will rise enthusiastically to this worthy challenge.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

Clearly the answer to these problems is *not* home birth midwifery. The **challenge, as always, is to improve our hospital-based maternity care system**. This requires that medical educators learn and subsequently teach the principles of physiological management  to all categories of professional caregivers. It compels us to utilize physiological management and evidenced-based practice parameters for all normal labors and births, regardless of whether the birth attendant is a doctor or a midwife. This includes the use of "patience with nature", non-drug pain management and "right use of gravity" by caregivers as well as the educating of the public about the benefits and improved safety of physiological management. It must be remembered that one does not have to be a midwife to use the midwifery model of  physiological management -- doctors can and should learn and use these safe and protective methods or if they choose not to use these time-intensive practices, to defer to professional midwives who do. To achieve this we must "normalize" normal labor and birth services in hospitals by staffing our L&D units with certified nurse-midwives who are empowered and supported in providing the non-interventionist, cost-effective midwifery care to healthy women.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**"Of all tyrannies, a tyranny exercised for the good of its victims may be the most oppressive."**

 **CS Lewis**

1. Journal of the American Public Health Association, Vol 5 1915, Boston, Mass;

2. Transactions of the American Association for the Study and Prevention of Infant Mortality, annual meetings 1911, 1912, 1912, incl Dr Joesphine Baker, MD �School for Midwives�, 1911;

3. 13th Annual Meeting of the Am. Assoc. of Obstetrics and Gynecologists, Newark, NJ James Harrar, MD �Causes of Death in Childbirth; Maternal Mortalities in 100,000 Confinements at the New York Lying-In Hospital�, p. 38-41;

4. "Into This Universe , by Alan Frank Guttmacher, MD , Associate in Obstetrics, John Hopkins University Viking Press, 1937, Excerpts from �Safer Childbirth�, Charter 4, p. 329;

5. The Official Plan to Eliminate the Midwife 1899 to 1999, Liberty for Women, McElroy, 2002;

6. 13th Annual Meeting of the Am. Assoc. of Obstetrics and Gynecologists, Newark, NJ Julius Levy, MD  �The Maternal & Infant Mortality in Midwifery Practice in Newark, NJ� 1917

7. *C-Section to Prevent Cerebral Palsy: Results May Be a Wash;* Ob.Gyn.News; April 15,2002, Vol 38

8. �*Outcomes of Planned Home Birth In Washington State�  by Pang et al, 2002*]

9. National Center for Health Statistics Vol. 47, No 27, *The* *Use of Obstetric Interventions 1989-97]*

10. NCHS report �Births: Preliminary Data for 2001�; NVSR Vol. 50, No. 10. 20 pp. for the year 2001]

11. *Elective C-section Revisited*, Ob.Gyn.News; August 1, 2002, Vol 36;

12. *Elective Cesarean: An Acceptable Alternative to Vaginal Delivery?* Peter Berstein, MD, MPH]

13. Cesarean Birth Associated with Adult Asthma -- ObGynNews, 6/15/01, Vol  36, N0. 12)

14. CDC - *Safe Motherhood 2002*

15. *Cesarean Rate Portends Rise in Placenta Accreta, Maternal mortality 7%* Ob.Gyn.News Mar 1 01, Vol 36;

16. *Last 50 Yrs Show 10-fold Raise in Placenta Accreta � behind 50% of emergency hysterectomies*, Ob.Gyn.News Dec 15, 2001;

17. *Placenta Previa, C-section History Ups Accreta Risk*; Ob.Gyn.News Sept 15, 2001, Vol 36;

18.  CME Review Article 24 � *Diagnosis and Management of Placenta Percreta: a review*, Vol 53, No 8, 1998

19. *Elective C-section Revisited*, Ob.Gyn.News; August 1, 2002, Vol 36

20. *Elective Cesarean: An Acceptable Alternative to Vaginal Delivery?* Peter Berstein, MD, MPH, published 9/16/02  on Medscape web site, <[www.medscape.com/viewarticle/44120](http://www.medscape.com/viewarticle/44120)>

21. A Guide to Effective Care in Pregnancy and Childbirth�, published 2000

22*.* �Listening to Mothers� survey � Report of the 1st national US survey of women�s childbearing experiences, MCA, conducted by Harris Interactive - October 2002

23. Murphy and Fullerton, Outcomes *of intended home birth in nurse midwifery practice: a prospective descriptive study*;

24. *The Cost Effectiveness of Home Birth* Journal Nurse Midwifery, Jan-Feb1999;

25. *Outcomes of planned home birth versus planned hospital birth after regulation of midwifery in British Columbia*; 2002, Journal of Canadian Medical Association;

26. *Home Birth: A Safe Low-Risk Birth Option � Review of Literature Documenting Safety, Guideline for risk reduction*, March 1998, prepared for insurance industry

27. *Perinatal death associated with planned home birth in Australia: population-based study*, British Medical Journal 1998;317:384-388

28. Safety of Alternative Approaches to Childbirth"' Dr Peter Schlenzka, PhD, Thesis, Stanford University, March 1999

29. *Violence Against women in Healthy-care institutions: an emerging problem* The Lancet, 5/11/02

30. [List of Home Birth references compiled in United Kingdom](http://docs.google.com/Citations%20or%20text%2002/index_of_research_on_home_birthUK.htm)

**Email from lead author in response to questions on operative rate for two cohorts**

Dear Faith Gibson,

I thank you for your interest in this paper.

We did not look at the rate of epidurals, episiotomies, vacuum extraction, forceps, and Ceaserean births in these two cohorts, as the questions that we were addressing was specifically on whether there were differences in neonatal and maternal outcomes that would be common to the two cohorts. For example, Ceserean births would not take place in home births, at least not intentionally, so there would not be a rate ratio between the two groups.

The entire article is available in this month's Obstetrics and Gynecology.

Sincerely,

Jenny Pang

last updated 06/14/06 10:51 PM