�The primary objective of copyright is not to reward the labor of authors, but "[t]o promote the Progress of Science and useful Arts." To this end, copyright assures authors the right to their original expression, but encourages others to build freely upon the ideas and information conveyed by a work. This result is neither unfair nor unfortunate. It is the means by which copyright advances the progress of science and art.� -- Justice Sandra Day O'Connor (Feist Publications, Inc. v. Rural Telephone Service Co., 499 US 340, 349(1991)

**Dear Bob,**

It seems we share a number of attributes and interests. The most obvious is our interest in promoting evidence-based practice in midwifery and medicine, and our �wonderment� that factual data irrefutably identifying harmful or ineffective practices so often does not lead to appropriate changes in regard to maternity care. A second area of mutual interest is in the history, use, misuse and abuse of episiotomy and our frustration that misuse and abuse far out-weighs its �right use�.

Lastly we are both experiencing a near total political impotence in making any kind of meaningful impact on the �system�  -- that is, functioning as an effective change agent in regard to the misuse of an injurious (occasionally fatal) surgical procedure that is ineffective, painful, debilitating and to quote someone we both know well, that �**women�often reveal a startling depth of enmity for**�.

To that end you embarked on an exhaustive five-part literature review on episiotomy, four parts of which were published in a peer-reviewed obstetrical journal 6 years ago. Woolley RJ. Benefits and risks of episiotomy: A review of the English-language literature since 1980. Part I. Obstet Gynecol Survey 1995; 50:806-820  Part II. Obstet Gynecol Survey 1995; 50:821-835. Of course midwives think your work is wonderful. I�m sure a few docs have taken the information to heart but generally, the entrenched notions of the medical community grind onward with little or no change. I notice that you have not been awarded the Noble prize for needed reform in obstetrical medicine or even designated as a �**Registered National Treasure**� � an honor you certainly deserve. Instead, it�s the same old arguments between yourself and the �gang� on OBGYN.NET discussion group. One should not confuse typing with writing.

On my part, I posted your email of 9/13/97 (part V of your literature review) which so elegantly identified the dimensions of the problem, speculated on its origins, proposed simple effective remedies, and bemoaned the many �embarrassing facts� of medical practice including the general refusal of physicians to modify their behavior despite excellent evidence. This neglected little gem lived on my web sites for nearly 4 years with (to my knowledge) absolutely no effect. **Nobody reads it, nobody care**. Are you as sad about this as I am? Have you noted (as I have) that nothing either of us is doing in regard to this subject is helping? Aren�t you just a tiny bit frustrated by this inability to make a difference in something that is so vital to the wellbeing of childbearing women (perhaps you have a wife or a daughter or a son that may marry). Doesn�t some part of you want to use the God-given talent and insight so generously endowed on you to achieve a godly purpose?

Recently the problems you so eloquently described have taken on a new urgency. In June 2000 the current ACOG president began publicly promoting medically unnecessary cesareans as the ultimate choice in reproductive �freedom�. The mere possibility of pelvic floor damage subsequent to vaginal birth has become the rationale for promoting the idea of cesarean on demand as �safer�, �better�, �maybe should even be routine� and simply a matter of a �woman�s right to choose�. On *Good Morning America*, Dr. Harer answered Diane Sawyer�s question on relative safety between normal birth and elective CS by saying: �For the mother, the immediate risks for a cesarean section are a little higher, but the longer term risks of pelvic dysfunction, urinary incontinence, anal incontinence, pelvic dysfunction -- those risks are higher for vaginal birth and over the long time I think that the risks balance out � there really is no big difference.�  Perhaps Dr. Harer, busy as he is representing the country�s 30,000+ ACOG obstetricans, is even more unfamiliar with the professional literature than most physicians.

This obstetrical romance with prophylactic cesarean is based on the **erroneous** idea that damage to the mother�s pelvic floor is an unavoidable  �collateral damage� of vaginal birth. It is intimately tied to obstetrical profession�s historical preference for episiotomy (along with a host of other interventions), coupled with the profession�s failure to teach, learn or utilize physiologically effective (midwifery-based) techniques for managing the �perineal phase� of expulsive labor and ultimately the failure of episiotomy to �protect� against pelvic floor damage. The obstetrical profession has never acknowledged the value (or even the existence!) of non-medical (ie, physiological) management techniques which historically have proven successful at preventing prolonged or ineffective pushing (thus reducing the risk of fetal distress) and at preventing or reducing perineal trauma during childbirth (and subsequent pelvic floor damage)

It seems that obstetricians have yet to discovery the laws of gravity and proudly flaunt their communal membership in the **obstetrical division of the Flat Earth Society**. This is accomplished by giving the mother labor-retarding narcotics and pelvic-floor numbing anesthesia, requiring her to push lying on her back or sitting at a 45 degree angle on her sacrum, while urging her in prolonged breath-holding and maximally hard, prolonged expulsive efforts � all non-physiological tactics amply identified as unnecessary, ineffective and even detrimental. Weight bearing on the maternal sacrum closes down the pelvic outlet by one quarter to one third while requiring the baby to be pushed uphill at a 60 degree angle against gravity through a partially closed door, a feat many first-time mothers cannot manage without damage to either themselves or their babies, irrespective of the use (*or not*) of episiotomy. These iatragenically-created problems are then perceived by doctors to be proof of a fatal design flaw in normal reproductive biology that can only be overcome by eliminating vaginal birth all together!

An astonishing notion is now being promoted by the obstetrical community -- that vaginal birth is so damaging to mothers, so dangerous to babies, so �old-fashioned� and backwards that only its total elimination will do. This is one of the most pernicious developments in the ignoble history of the obstetrics. (see <http://www.collegeofmidwives.org/safety_issues01/rosenbl1.htm>) It would change the focus of a physician�s care from attending to the needs of the mother during spontaneous vaginal deliveries to determining when fetal lung maturity was achieved so that the CS could be scheduled before the mother went into spontaneous labor by mistake and (gasp!) gave birth naturally!

Fifteen years later the chilling and unthinkable words of the Doctors Feldman have around again, only this time to meet with enthusiastic acceptance:  The Drs Feldman make a statistical case for cesarean surgery as �saving� babies with only a little �excess� or �extra maternal mortality� and opin that the �low cost of excess maternal mortality� may be a price worth paying. Here is a short excerpt from their article in NEJM, May 1985 entitled **Prophylactic Cesarean Section at Term*?***:

p. 1266 �.the **number of extra women dying** as a result of a complete shift to prophylactic cesarean section at term would be 5.3 per 100,000�.  This may be the proper moment to recall that the number of fetuses expected to suffer a disaster after reaching lung maturity is between 1 in 50 to 1 in 500. � if it could save even a fraction of the babies at risk, these calculations would seem to raise the possibility that a shift toward prophylactic cesarean section at term might save a substantial number of potentially healthy infants at a relatively low cost of excess maternal mortality.

We probably would not vary our procedures if the cost of saving the baby�s life were the loss of the mother�s. But **what if it were a question of 2 babies saved per mother lost**, or 5 or 10 or (as our calculations roughly suggest) as many as 36 or 360? �.  Is there some ratio of fetal gain to maternal loss that would unequivocally justify a wider application of this procedure?

p. 1267�.is it tenable for us to continue to fail to inform patients explicitly of the very real risks associated with the passive anticipation of vaginal delivery\* after fetal lung maturity has been reached?  If a patient considers the procedure and decides against it, must she then be required to sign a consent form for the attempted vaginal delivery?  (\*emphasis mine)

My question for doctors is quite different from the Doctors Feldman, as I want to know if it is tenable for them to continue to fail to inform healthy women of the high risk associated with �obstetrics as usual�, what with its high rate of risky procedures such as induction of labor and cesarean surgery and its low or non-existent use of effective and low-cost methods to reduce these problems, such as routinely **staffing hospitals with nurse-midwives**, which, unlike physician care providers, enjoy both a low rate of interventions (especially induction, episiotomy and Cesareans) while having excellent perinatal outcomes and achieving all this for a third less money? ( Midwives Deliver Healthy Babies With Fewer Interventions Dr. Roger Rosenblatt, MD University of Washington )

In my mind the issue is not simply that we stop this cascade of pernicious practices but also that we employ the universally beneficial ones and I apply that idea both to patients and practitioners. The current legal situation is hell for one and all. In that regard the important issues are not only the physiological management of labor versus the medical (and non-physiological!) management but also the host of real psychological and social problems that confronts each woman during the childbearing year. Women benefit enormously from the opportunity to have uninterrupted, face-to-face time (30 minutes minimum) with a caring and experienced professional who will listen to her and provide helpful guidance in the areas of PP recovery, sleep-deprivation, breastfeeding, psychological adjustment of other siblings and her husband to the expanded demands on her time, how the mother herself is feeling and the level of her ability (or inability) to cope. This is the crucial time for caregivers to pick up the early warning signs of post-postpartum depression.

Presently the public erroneously assumes that detection and prevention of PPD are an important aspect of standard obstetrical care but you and I know that is not so (with the possible exception of Minnesota and its routine use of the Edinburgh PPD scale). With the exception of a single 6 weeks check-up, obstetricians don�t provide any kind of follow-up care (especially not psychologically-orientated) to a new mother nor does the baby�s pediatrician, despite a PPD rate of 12 to 20%. (Predictors, prodromes and incidence of postpartum depression. Chaudron LH, J Psychosom Obstet Gynaecol 2001) Except for community-based midwifery, there is no continuity of care for childbearing women or functional safety net to prevent PPD or to catch it early on, before it damages the parent-child bond, the woman �s relationship with her husband or results in harm to herself or others. (Do not minimize signs of postpartum depression! Early intervention essential to prevent negative consequences for the child. [Article in Swedish] Wickberg B, Hwang P. 2001). I�ll bet that Andrea Yates received the best medical care that obstetrics had to offer during each of those five labors & births (continuous EFM, epidural & episiotomy!) but ultimately society and the medical profession drastically failed each of her five children when it failed to detect and respond to her PPD five times in a row. Apgars of ten and ten for a child at birth are wonderful but floating face down in the bathtub each child was left with apgars of zero and zero.

# **Necessary Change**

There are three areas of maternity care reform crying out here at the cusp of the 21st century. The first is the continuing absence of the �right stuff�, i.e. the failure of contemporary maternity care to utilize the midwifery model of care as the standard for normal birth. Midwifery principles and practices are only conspicuous by their absence. Approximately 70% of childbearing women are healthy and have normal pregnancies and yet 95% of them are simultaneously denied the cesarean-reducing benefits of midwifery management (which can be employed by physicians as well as midwives) while being subjected to cesarean-increasing, �business as usual� interventist obstetrics. (Peter Schlenzka thesis) This is to say that labor was �managed� by a busy L&D nurse who was out of the labor room 79% of the time (Gagnon, & Waghorn, 1996 �Supportive Care by Naternity Nurse: A Work Sampling in an Intrapartum Unit� Birth, 23:1; 1-6) and a physician who was not even present in hospital until the last few minutes before the birth or who only came in to perform the Cesarean after things began to go awry. (Dr Rubsamen, MD, LL.B *The Obstetrician�s Professional Liability -- Awareness and Prevention, 1993)*

The second category of concern is the legal consequences of the absent-obstetrician syndrome, which shows up as a vastly increased rate of malpractice claims and litigation, making the profession of obstetrics disproportionately expensive (and way more defensive!) than it need be. Dr. David Rubsamen, MD, LL.B., an expert in the field of obstetrical liability and author of the *Professional Liability Newsletter*, has collected a sample set of 63 obstetrical malpractice cases involving permanent brain damage and subsequent litigation. In his book *The Obstetrician�s Professional Liability -- Awareness and Prevention* he presents these cases as "instructive" and "cautionary tales" designed to acquaint readers with the malpractice traps that have made obstetrics a "loss leader" for liability carriers throughout the US.

The absence of an awake, decision-making, practitioner at or near the bedside of the laboring mother played a central role in approximately 2/3s of these malpractice cases, particularly those which necessitated telephone conversations between nurses at the hospital and the doctor who was not. This gave rise to various forms of misunderstanding or miscommunication between those present at the bedside (non-practitioners who don�t have the necessary training to intercede on their own authority) and those absent from the scene (who have both training and responsibility but are not present to use them). An �absent obstetrician�, combined with an unexpected medical situation (the basic reason families choose hospital care!), results in an adverse outcome for mother or baby far too often, followed by a malpractice lawsuit for the physician. Litigation occurs in regard to what was said by whom, whether or not a phone call was made by the nurse to the doctor or the exact timing of the call as the hospital nurse and independent obstetrician each blame the other for the unfortunate outcome.

Even when the doctor is asleep in the call room of the hospital, communication breakdowns occur as nurses may be inexperienced (or a �temp� from another floor or an agency) and not recognize a serious situation or are hesitant to wake the doctor for what may seem like a "trivial" reason. This break in the continuity of care may cause other kinds of problems, as the doctor doesn�t actually know what has and has not been tried or exactly how long a situation has persisted. It is the usual malpractice nightmare, but unique in this respect -- it is the one malpractice risk that is the most predictable and most preventable. �As a result of nail the rider was lost�. One of the reason that approximately 10% of obstetricians get sued each year is bBecause doctors do not �do� labor. The rest of us pay the bills. The �absent obstetrician� is a preventable accident waiting to happen. However, problem would disappear overnight if labor and delivery units were staffed by professional midwives who were continually present during active labor and who routinely delivered all healthy women with normal pregnancies and spontaneously progressive normal labors (unless the mother requested to be attended by a physician). The economic advantage is this would be astounding.

 Episiotomy and Right Management of

Physiological Perineal-Phase � a good place to begin

Of course, item number three is the issue of episiotomy and physiological perineal-phase by physicians. As you know so well, these desired changes in physician behavior have two distinct parts � doctors must stop doing the wrong thing (episiotomy) and must start doing the right thing � use of traditionally successful physiological management of 2nd stage labor employed world wide with excellent results. Simply not doing episiotomy is not enough, especially if that translates into preventable perineal trauma caused by extreme efforts of pushing the baby uphill against a closed door or **if fear of pelvic floor damage** results in increased use of medically-unnecessary Cesarean surgery. How are we to bring the necessary changes? In answer to my own question I would say �one step at a time�.

A very good first step would be for you to actually publish Part V, chronicling the reluctance of your fellow physicians� to **�adopt a more scientific view of the evidence available on the subject of episiotomy, disclose this information to our patients, listen to their perspective, and, when the moment comes, choose to heed the evidence over our prejudices, we could hardly fail to reduce dramatically the use of this injurious procedure**�.

It has now been 4 years since you circulated Part V of your literature review on the OBGNY.NET discussion group and 6 since part I-IV were published. With a current episiotomy rate of 56% and annual birth rate of approximately 4,000,000, and assuming a truly �necessary� episiotomy rate is only about 6% (the rate of midwives in Holland), that means that 50% or about 2 million medically-unnecessary �injurious procedures� are performed annually by uninformed doctors each year. Multiplied by 6 years that equals 12 million unnecessary episiotomies over the course of just a few years ~ that�s a lot of avoidable loss of maternal blood and a lot of pain and no doubt, a lot of significant complications, all for no good social or medical purpose.

Frankly, I think the time for waiting is long past. It seems unlikely that any peer review journal would be willing to print such astute observations that are critical of physicians as communicated in Part V. However, *Midwifery Today*, the *Birth Gazette, the Journal of Midwifery* and *Lifelines*, the journal for *AWHONN,* are all good choices. Any one of them would gladly breathe new life into your prose and enable us to elevate the quality of the public and professional debate.

In the mean time, I am writing an article for publication on these topics and the relationship between the misuse and abuse of episiotomy and the many negative consequences, including its association the institutionalized lack of physician training in physiological management of labor and price paid by us all for such deficiencies in medical education and practice such as the �prophylactic� cesarean epidemic and return to �once a Cesarean, always a Cesarean� for VBAC moms. I intend to publish in one of the national �mother-baby-midwife-friendly� magazines. It will include an extensive commentary and critique of the ideas in your published literature review, including Part V, which technically (for purposes of copyright law) has already been published on the OBGYN.NET discussion group. A critique of part V falls squarely under the �fair use� doctrine. I have spoken to a lawyer, researched relevant laws and been in contact with the friendly folks at the Electronic Frontier web site. They have provided the following quotes, explanations of copyright law and the fair use doctrine.

�The primary objective of copyright is not to reward the labor of authors, but "[t]o promote the Progress of Science and useful Arts." To this end, copyright assures authors the right to their original expression, but encourages others to build freely upon the ideas and information conveyed by a work. This result is neither unfair nor unfortunate. It is the means by which copyright advances the progress of science and art.� -- Justice Sandra Day O'Connor (Feist Publications, Inc. v. Rural Telephone Service Co., 499 US 340, 349(1991)

�The genius of United States copyright law is that, in conformance with its constitutional foundation, it balances the intellectual property interests of authors, publishers and copyright owners with **society's need for the free exchange of ideas�**

�Fair use refers to a privilege in those other than the copyright owner to use the copyrighted material in a **reasonable manner** without the consent of copyright owner. At its core is a fundamental conviction that not all copying should be banned, particularly in **socially important endeavors**.�

 �Some examples listed in the statute that would generally be considered a fair use to copy copyrighted material include: **Criticism, comment, parody, news reporting, teaching, scholarship, research.�**

**�**Several important limitations to the author's exclusive rights exist under copyright law to encourage citizens to **fully and openly exchange and build upon information to increase the public's knowledge**.�

 �Taken together, fair use and other public rights to utilize copyrighted works, as confirmed in the Copyright Act of 1976, constitute indispensable legal doctrines for **promoting the dissemination of knowledge**.�

�The factors to consider include: 1.The **purpose and character of the use**, including whether such use is of a commercial nature or is **for nonprofit educational purposes** -- Courts are more likely to find fair use where the **use is for noncommercial purposes**. 2. The nature of the copyrighted work -- A particular use is more likely to be fair where the copied **work is factual** rather than creative.�

Certainly we both were always aware that I had (and have) the legal authority to �critique, comment, parody, report, teach�, engage in �scholarly dissertations� and other similar �fair use� for the express purpose of this socially important endeavor.

Until now I have chosen not to exercise that right. It seemed to me that what would **best honor your work was for you to state you ideas in your own voice**. Ideally that would come about by publishing your original work in all five parts. For whatever reason, that did not happen and Part V has taken on a life of its own, published as it was on the OBGYN.NET (distribution of 1000+) and then posted by me on [www.GoodNewsnet.org](http://www.goodnewsnet.org/) and [www.CollegeofMidwives.org](http://www.collegeofmidwives.org/) . I have been (and remain) willing to do what ever I could/can to make this work for you � leave your name off, put your name in, identify the article posted as an �unauthorized reprint� so as not to damage your changes of independent publication or expose you to charges of plagiarism of another physicians writings, etc. Taking the �blame� for a theoretical copyright violation was a strategy to balance your personal and professional desires with the absolute need of women to have this dangerous and dysfunctional system fixed before another 10 or 20 million unnecessary procedures are performed.

Sadly it seems that the only avenue for a full and open exchange of these ideas and the opportunity to build upon information that will increase the public's knowledge in the right use, misuse and abuse of episiotomy will have to come from my voice, not yours. As I was walking in the park this evening at sunset, musing on the Eternal Verities of God, life, love and human endeavors and praying for inspiration, an additional possibility came to me. It seems to me that the most appropriate and dignified conclusion to this current controversy would be to give your work a forum for publication in its entirety ~ that is, to repatriate part V with parts I-IV on Ronnie Falcao�s web site and/or the [www.collegeofmmidwives.org](http://www.collegeofmmidwives.org/).

Please consider these options carefully and contact me as to your preference. Your voice is a good one and should not be silenced, muted or diluted.

I leave you with one additional thought:

�Now, if Plato was the proverbial Johnny Appleseed of ideas for having written them down and dispersed them, Socrates, his friend and mentor, is the midwife for having exercised their birth. A passion for the delivery of ideas was what both of these two ancients shared in common. Far from seeking to quell the transmission of ideas, laws of copy protection seek mostly to encourage their continued creation and expansion. That much seemed evident from the start. In this respect, Socrates and his art of the dialectic throw into relief the importance of a healthy and vibrant relationship between the creators/providers and the enlightened self-interested as benefactors and patrons.�  Gerald Martin, gmartin@well.com

Warm regards,

faith ^^O^^

650 / 328-8491

Pacific Daylight Savings Time

PS it would be best to postpone future phone conversations until I am awake. Last time I had been up most of the night with a Gr 8 that I transferred to a hospital in San Francisco with PPROM and a slight temp. Baby NSVD at 2:11 AM, all WNR except for long drive home, did not get to bed til after 5 am.