**Links:** [**B - policy problems**](#gjdgxs)**,** [**C- Induction &Pitocin**](#30j0zll)**;** [**D - Cesareans**](#1fob9te)**, or** [**E - Politics**](#2et92p0)[**YouTube Video Links**](#3znysh7)

|  |  |  |
| --- | --- | --- |
|  | Best Evidence |  |

**Special Link for**  [**CIMS --> New View Focus Group**](http://docs.google.com/index_files/Index_Healthcare_Repair_Group_2009.htm)  **Goal: a 1,000 people, a 1,000 days, and a 1,000 acts -- big and small -- to facilitate universal access to a national system of cost-effective, evidence-based healthcare**

[**Web site resource for Ning platform**](http://docs.google.com/Ning.com_PolitialAction_March2010/NingSite_PoliticalAction-Info_Mar2010.htm)

****  **Section A -**  Best evidence for Physiological Management of Normal Birth, an Independent Midwifery Profession and the Safety of Planned Home Birth (PHB) in Healthy Women with Normal Pregnancies and access to medical services for complications or if requested by the mother

**A-1**  [BMJ study on Planned Home Birth, as reported in *ObGynNews* July 15, 2005](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/OBG_PHB_BMJ_favorably_15July05.pdf)

**A-2**   [The Guardian, United Kingdom; Feb 6, 2007](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/UK%20ups%20childbirth%20safety_07.pdf)

            Beginning in 2009, NHS to recommend  **PHB with a midwife as the preferred form of care** **for healthy women**

**A-3 **  **New!  **  [Evidence-Based Maternity care: What Is It and What Can It Do?](http://www.childbirthconnection.org/pdf.asp?PDFDownload=evidence-based-maternity-care) Oct 2008

****  just released pdf in conjunction with the  *Milbank Memorial Fund* and *Reforming States Group* and co-written by Carol Sakala and Maureen Corry from *Childbirth Connection*

**A-4**   ****  ****   [Making Normal Birth a Reality](http://docs.google.com/Citations_Studies_2008/UK_norm_birth_consensus_Dec07.pdf) - a Consensus Statement from the Maternity Care Working Party  and endorsed by the UK�s Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Midwives, the National Childbirth Trust, and other organizations. **Dec 2007**

** D**efines normal birth is: �**without induction, without the use of instruments, not by caesarean section and without general, spinal or epidural anaesthetic before or during delivery**� (see p. 3 of document for details)**,**  calls for action to increase rates of �normal birth� where appropriate in order to minimize morbidity and complication rates. "Choice of place of birth including home birth, a midwife-led birth centre and a maternity unit with midwives."

**A-5**    ** **  A "Must Read! document: [Four Contrasting Studies on Safety:](http://docs.google.com/Political_Action_2006/Contrasting-4-Studies_Dec08.pdf)

**1) unattended, (2) lay midwife-attended, (3) professional midwife-attended and (4) obstetrician-attend**

**(surprise! -- lay midwives did the best, with the least use of resources)**

**A-6**   [Midwife Care Is as Safe as Physician-Led Care for Nepalese Women with Low-Risk Pregnancies](http://docs.google.com/Citations_Studies_2008/Journal%20Int.%20FamilyPlanPerspectives_MidwiveVsPhysician2004.html)**;**

**DIGEST-- International Family Planning Perspectives Volume 30, Number 1, March 2004**

**A-7**   [Study Compares Maternity Costs between consumer driven plans and traditional coverage](http://docs.google.com/Citations_Studies_2008/KaiserStudy-ComparesMatCosts_2007.html)

             Kaiser Family Foundation and the March of Dimes (quotes actual costs, good source of data)

**A-8** [**Pew Report on Midwifery in the 21st Century (76 page PDF)**](http://docs.google.com/Political_Action_2006/PewReport_21stCen_midwifry.pdf)  ****

**A-9** [**Historical List/Bibliography of 74 Studies on Midwifery care and Planned home Birth - 1977 to 1995**](http://docs.google.com/PHB_List%2074%20Studies_1977-95.pdf)

**A-10**   [**Worldwide Stats for Childbirth, PNMR & MMR**](http://docs.google.com/Citations_Studies_2008/AnnualStats_Worldwide_birth_Dec08.html)  ~ Neonatal and Perinatal Mortality ~ Country, Regional and Global Estimates � p. 29-34; World Health Organization, 2006

[Q: What Scares Doctors? A: Hospital!](http://docs.google.com/Citations_Studies_2008/WhatScaresDoctors_TIME_May-2006.html)  --  **TIME Magazine, Cover Story, May 1, 2006**

Interview of Dr. Don Berwick, President, Institute for Healthcare Improvement (IHI) & expert in  medical errors and other aspects of nosocomial.

**Section B**

Policy Problems with the Current Maternity Care Policies

Danger of Interventionist practice for babies - failure to use physiological cord clamping-cutting

[Neonatal Resuscitation: Life that Failed](http://docs.google.com/Citations_Studies_2008/DrMorley_NNResuscitation_Annotated_Jan2011.htm) ~ by George Malcolm Morley, MB ChB FACOG

A scientific paper provides vital information on the value of physiological cord clamping ***under many diverse circumstances*** � especially premature babies, distressed neonates and following any Cesarean deliver, but particularly an emergent one performed for fetal distress. This a game-changer in the practical, political, [legal and economic arena](#tyjcwt).

Interventionist Obstetrics for healthy women

**B-1**   [An Uncontrolled Experiment: Elective Delivery Predominates in the United States](http://docs.google.com/Citations_Studies_2008/Carol%20Sakala%20Analysis%20Birth-NAm-2006.html);

                            Carol Sakala�s Letter from North America: -- Birth 33:4 December 2006

**B-2**   [Patient-choice vaginal delivery?](http://docs.google.com/Citations_Studies_2008/Patient-choiceVaginalDel_AnnalFamilyMed_06.html)   **Annals of Family Medicine 01-MAY-06**

"Patient-choice cesarean delivery is increasing in the United States. The American College of Obstetricians and Gynecologists supports this option, citing ethical premises of autonomy and informed consent, despite a lack of evidence for its safety. The growing  **pressure for cesarean delivery in the absence of a medical indication** may ultimately result in a decrease of women's childbirth options. ....  **Why advocate for patient choice only when that choice is a cesarean delivery?**

Key words: Cesarean; surgical procedures, elective; patient choice; vaginal birth after cesarean; breech presentation

**B-3**   [Effects of Hospital Economics on Maternity Care](http://docs.google.com/Citations_Studies_2008/Hospital-Economics_Maternity%20Care_2004.html)Susan Hodges with Henci Goer

                            Reprinted from **Citizens for Midwifery News**, Spring/Summer 2004 --

**B-4**    [Facility Labor & Birth Charges, U.S., 2003 By Site and Method of Delivery](http://docs.google.com/Citations_Studies_2008/Comparison_birthcharges_MCA_2003.html)

                       Maternity Center Association 2004 (Now known as "Childbirth Connection")

**B-5** [Birth Environments - Design of L&D units - 1992](http://docs.google.com/Political_Action_2006/BirthEnvironment_HospEconomics_1992.pdf)

                        Economics of  hospital obstetrical departments & Med-Mal Insurance as a money maker

**B-6**  ["Listening to Mothers" Survey](http://www.maternitywise.org/listeningtomothers/index.html)  � for the first time, hear what mothers are saying about their childbearing experiences.

**$12 for PDF from Childbirth Connection web site**

**B-7**  [Maternal Mortality Rises Previous 3 years](http://docs.google.com/MM_CMQCC_12-Mar-08.pdf)  **-- 2007**;

**Maternal deaths more frequent after C-section than normal birth ~**

**Compilation of reports and MM Stats from California, New York and the UK**

**B-8**  [May 2006 U.S. has second worst newborn death rate in modern world,](http://docs.google.com/Citations_Studies_2008/CNN_2ndWorst_PMR_US_May2006.html)

**report says 2 million babies die in first 24 hours each year worldwide -- May 10, 2006 CNN ~Jeff Green**

**B-9**  [History of Maternal-infant health and maternity care in the US 1900-1900](http://docs.google.com/Citations_Studies_2008/CDC_MaternityCare_1900-99.htm) (CDC)

"At the beginning of the 20th century, for **every 1000 live births, six to nine women** in the United States died of pregnancy-related complications, and approximately **100 infants died before age 1 year** (1,2). From 1915 through 1997, the i**nfant mortality rate declined greater than 90%** to **7.2 per 1000 live births**, and from 1900 through 1997, the **maternal mortality rate declined almost 99%** to less than 0.1 reported death per 1000 live births (**7.7 deaths per 100,000** live births in 1997) (3) ([Figure 1](http://www.cdc.gov/mmwR/preview/mmwrhtml/mm4838a2.htm#fig1) and [Figure 2](http://www.cdc.gov/mmwR/preview/mmwrhtml/mm4838a2.htm#fig2))

**Environmental interventions [sanitation, pasteurization of milk], improvements in nutrition, advances in clinical medicine, improvements in access to health care, ... surveillance and monitoring of disease, increases in education levels, and improvements in standards of living** contributed to this remarkable decline (1)."

Maternal mortality rates were highest in this century during 1900-1930. **Poor obstetric education and delivery practices**  [by doctors] **were mainly responsible for the high numbers of maternal deaths, most of which were preventable** (2) ....  **Inappropriate and excessive surgical and obstetric interventions (e.g., induction of labor, use of forceps, episiotomy, and cesarean deliveries) were common and increased during the 1920s. Deliveries, including some surgical interventions, were performed without following the principles of asepsis. As a result, 40% of maternal deaths were caused by sepsis (half following delivery and half associated with illegal .. abortion) with the remaining deaths primarily attributed to hemorrhage and toxemia.**  [Editorial comment: It should be noted that these dangerous practices had **nothing to do with midwifery care or place of birth**. These obstetrical customs reflected the unbridled and unscientific medicalization of childbirth without oversight or accountability.]

The 1933 White House Conference on Child Health Protection, Fetal, Newborn, and Maternal Mortality and Morbidity report **demonstrated the link between poor aseptic practice** [by doctors]**, excessive operative deliveries, and high maternal mortality.** This and earlier reports focused attention on the state of maternal health and led to calls for action by state medical associations (13).

The **discovery and widespread use of antimicrobial agents (e.g., sulfonamide in 1937 and penicillin in the 1940s) and the development of fluid and electrolyte replacement therapy and safe blood transfusions** accelerated the decline in ... mortality

**B-10 -->B-14** Three-part report on maternal mortality in Gambia (southern tip of Africa) in 2003 --

                               remarkable for what it *isn't* -- the common assumption is neglected childbirth is quite off the mark.

                               Instead, **100% of women sought care and of the 42 maternal deaths, 41 occurred in the hospital**.

                               The one mother who died at home had delivered in the hospital and been discharged 6 days earlier.

                               This is an interesting and informative read.

**B-11** [Maternal Mortality in the Gambia: PhD Thesis by Mamady Cham](http://docs.google.com/Citations_Studies_2008/MM_Gambia_Thesis_may03_Editd-08.html)

**B-12** [Paper #1](http://docs.google.com/Citations_Studies_2008/MM_Gambia_PAPER_1_May03.html)  Maternal Mortality in Bansang Hospital, The Gambia:

                                  Levels, Causes and Contributing Factors

**B-13** [Paper # 2](http://docs.google.com/Citations_Studies_2008/MM_Gambia_Paper2_Appendices.html) Maternal Mortality in Rural Gambia: What do we need to know to prevent It?

**B-14** [Q & A:  What we can do to prevent maternal deaths](http://docs.google.com/Citations_Studies_2008/MM-Q%26A_unknownOrigin.html)

**Web Editor's Note:** Two of the scientific papers cited below contain very good data but are long

                  and hard to read. In both cases, I have excerpted the most important information and included it with the citation link.

**Section C**

  Dysfunctional Obstetrical Practices

   Induction &"Pit to Distress"

**C-1**   **MUST READ:**   [New Practice Reduce Childbirth (Litigation) Risks](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/WallStJ_Reduce_CB_Litigation_excpt06zz.pdf)  --Wall Street Journal; 2006 J 

**C-2**  [Trials and tribulations of operative vaginal delivery;](http://docs.google.com/Citations_Studies_2008/Instrumental_births_07.html) **by A Vacca, et al;** Australia **- www.bjog-elsevier.com**

  **RCOG 2002 BJOG: an International Journal of Obstetrics and Gynaecology** PII: S1 47 0 -0328(02)01004-

**C-3**  [Bishop Score and Risk of Cesarean Delivery After Induction of Labor in Nulliparous Women;](http://docs.google.com/Citations_Studies_2008/BishopScore_Induce_CSrate_06.html)

Obstetrics & Gynecology 2005;105:690-697 � 2005

**C-4** [Management of Prolonged Pregnancy: Summary](http://docs.google.com/Citations_Studies_2008/AHRQ_EBP_ProlongedPreg.html) Number 53 ~ March 2002

**United States Agency for Healthcare Research and Quality Evidence Report/**Technology Assessment:

"There is **no direct, unbiased evidence that antepartum testing reduces perinatal morbidity and mortality in prolonged gestation**.  ...  Based on the observed absolute risk difference in the meta-analysis, at least **500 inductions are necessary to prevent one perinatal death**. Whether this is an acceptable trade-off at either the policy or individual level is unclear.

**Web Editor**: Here are the **actual numbers**  **per 1,000 pregnancies** [rounded up to next full decimal point] which are provided in this AHRQ report. They are amazingly tiny when seen in perspective. Also  the difference between the end of one week of pregnancy and the beginning of the next is negligible          :

"...gestational-age-specific stillbirth risk reaches a nadir at 37-38 weeks and then begins to increase slowly. Risks increase substantially after 41 weeks; **however, the absolute risk** between 41 and 43 weeks **is still low** -- between 1 and 2 fetal and neonatal deaths per 1,000 ongoing pregnancies that extend beyond 40 weeks but delivery by the 43rd week.

"antepartum stillbirth rates begin increasing after 40 weeks, with estimates  of:

(perinatal death per 1,000 pregnancies:

**1.0** to **1.1**    between 40 and 41 weeks,

**1.2** to **1.3**    between 41 and 42 weeks,

**1.3** to **2.0**    between 42 and 43 weeks

**1.6** to 6.3    **after** 43 weeks.

Although the risk of antepartum stillbirth increases with increasing gestational age, there is no evidence that allows determination of the optimal time to initiate antepartum testing. Specifically, there is **no evidence that testing prior to 41 weeks in otherwise uncomplicated pregnancies improves outcomes for either mother or infant**.

**C-5** [Amniotic-fluid embolism and medical induction of labour:](http://docs.google.com/Citations_Studies_2008/Induction%20of%20labour%20amniotic%20fluid%20embolism.html) **www.thelancet.com Vol 368 October 21, 2006**

a retrospective, population-based cohort study Michael S Kramer, Jocelyn Rouleau, Thomas F Baskett, K S Joseph,

                            for the Maternal Health Study Group of the Canadian Perinatal Surveillance System

**C-6** [Routine induction of labour at 41 weeks gestation: nonsensus consensus](http://docs.google.com/Citations_Studies_2008/Induction-Nonsense_BMJ_2002.html)  BMJ 2002**;**

Savas M. Menticoglou, Philip F. Hall Department of Obstetrics, Gynaecology and Reproductive Sciences,

                            University of Manitoba, Winnipeg, **Canada //**

Quote by Jonathan Swift, The Examiner, No. 15, November 9, 1710 (in original document)

                            "**Falsehood flies and the truth comes limping after; so that when men come to be undeceived,**

**it is too late: the jest is over and the tale has had its effect**."

**Excerpts:** "The **assertion that induction at 41 weeks results in fewer caesarean sections than expectant management is doubtful at best**. It is particularly difficult to reconcile with considerable and consistent evidence that induction, especially in nulliparae with unfavourable cervices, markedly increases the rate of caesarean sections24 � 32. In a four-year period in southern Alberta, **the caesarean rate for women induced in their 41st week was 23%, compared with 14% in those who laboured spontaneously in the 41st week**. The  SOGC (Society of Obstetrics and Gynecology in Canada) cautioned against induction before 41 weeks, in that ��particularly in nulligravida. . .**the likelihood of cesarean section may be twice as great when labour is induced as compared with spontaneous**��.

Why this should not be the case for induction at 41 weeks is **unexplained, and unlikely**. **Given the odds of stillbirth of 0.1% in the 41st week without induction for dates alone or special fetal surveillance, the influence of fetal risk is more likely that of *perception than reality***.

The appropriate counselling ��regarding the higher risks to themselves��, that the SOGC Clinical Practice Guidelines assert must be provided to women who reach 41 weeks of gestation, **should be that the higher risk is of caesarean delivery for dubious reasons, and that to avoid it they should labour and deliver where induction for dates alone is not the ritual at 41 weeks of gestation**.

It is uncertain that routine induction at 41 weeks will reduce the number of fetuses who die, and it is **arguable that such practice could increase perinatal mortality and morbidity**. **Attention is a limited resource.** The extra attention needed for such added induction and its consequences will draw attention away from women labouring spontaneously or who are being induced for more compelling reasons. A mother, or a fetus of less than 41 weeks who needed help, harmed because people were busy with somebody else who did not need help, will not be counted in morbidity and mortality analysis of intervention by induction of labour at 41 weeks of gestation.

The Canadian trial  resulted in a grave morbidity which we discovered during research into cervical cord injury. **A mother who had been *randomised* to induction was induced, with**  **prostaglandin**. **Precipitate labour** ensued, with rapid progress to full dilation, **severe decelerations**, **forceps** rotation and extraction. **The baby sustained high cervical cord injury and quadriplegia**. **This complication was not identified in the publication**, a subsequent reinterpretation, nor in the SOGC Clinical Practice Guidelines and there was **no such incident** [reported] in the study�s expectant cohort.

Almost a quarter of a century ago, the ... authors of an article entitled *Intervention and Causal Inferences in Obstetric Practice* cautioned that ��**as . . . interventions are applied to an increasingly large proportion of the obstetric and fetal population, a threshold will inevitably be reached beyond which the marginal risks of the procedure will outweigh the marginal benefits��**.

The �evidence� on which current practice and popularity of routine or as we prefer to think of it, ritual induction at 41 weeks, is based is **seriously flawed and an abuse of biological norms**. **Such interference has the potential to do more harm than good, and its resource implications are staggering.** **It is time for this 'nonsensus' consensus to be withdrawn**.

  [What Every Pregnant Woman Needs to know about Cesarean Section](http://maternitywise.org/mw/topics/cesarean/booklet.html)  ~ 2004 Maternity Center Association - Childbirth Connection --  **you can get a free download, but have to register, which is free**

**Section D**

  Dysfunctional Obstetrical Practices

   Cesarean Section, Increased Maternal and Neonatal Deaths, Delayed and Downstream Complications

**D-1** [Womb Service -- Why more women are making Cesarean Section their delivery of choice;](http://docs.google.com/Citations_Studies_2008/WombService_TIME_Apr-28-08.html)

                Time Magazine April 28, 2008 - an obstetrician with CDC suggests that in our technological and medicalized

                 society childbirth ...becoming more about simply getting a baby out safely and without incident and that we

                 are "**coming up with different cultural norms**"

According to this TIME magazine article, Mother Nature is not very nice to childbearing women. But those of us who live in wealthy industrialized countries are lucky -- we can just schedule an elective Cesarean section. This procedure is often referred to by the obstetrical profession as "**vaginal by-pass surgery**" -- a way to by-pass Mother Nature by by-passing the mother's birth canal (and incidentally, making both mother and father irrelevant to the process of their baby's birth, since neither of them are obstetrically trained surgeons). While presented as a value-neutral 'option', the descriptive language is uniformly positive: a safer, quicker, less painful, more predictable, all around better way to give birth.

*Womb Service* refers to this as a 'different cultural norm" -- a new obstetrical standard for a new century, one that substitutes major surgery for normal childbirth and calls it 'progress'. This is portrayed as a win-win' solution that benefits all parties -- mothers, babies, obstetricians, hospitals, health insurance companies, malpractice carriers and society. According to this perspective, C-sections are the patriot choice, making us happier and stronger, putting us at the head of the line, so America is better able to compete successfully in a highly competitive global economy.

The exact reason for this irrational enthusiasm is hard to pinpoint, but the science does not support any of the claims for better babies thru electively scheduled surgical delivery of healthy women with normal pregnancies. In fact, the scientific literature reveals that each of the perceived benefits (the promise to eliminate neonatal cerebral palsy and prevent of maternal pelvic problems, etc) is a major misrepresentation of the facts. Even the idea that we don't have enough data to draw any conclusions and the we need more research before the obstetrical profession can provide any guidance is just wrong. According to a consensus of the scientific literature, the benefits of medically-unnecessary Cesarean are far fewer and less frequent than advertised and there are far more serious and frequent complications than admitted to, including increased rate of emergency hysterectomy, maternal death and stillbirth in a subsequent pregnancy.

Below are links to 23 excellent examples of the scientific literature for Cesarean-related topics. This includes a general overview of the controversy, statistics, long and short term complications, delayed and downstream complications, the economic expense, the cost in human terms, the VBAC issue, and the newest wrinkle, **health insurance companies that are fusing coverage to women who have had a Cesarean** or **requiring them to submit to surgical sterilization** in order to be eligible for affordable health insurance.   Are we having fun yet?

**D-2**   [Why Does the Cesarean Section Rate Keep Going Up?](http://docs.google.com/Citations_Studies_2008/WhyCS-rate_UpUpUp_MCA_07.html)   Childbirth Connection 2007

**D-3**  ** MUST READ :**   [Myth of the Ideal C-Section Rate**;**](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/AJOG_Myth_Ideal_CSRate_2006Excerpt.pdf) **(excerpt only)**

Dr RM. Cyr, MD Am Jour Obstet Gynecol 2006

**D-4** [Caesarean delivery rates and pregnancy outcomes:](http://docs.google.com/CS-SVD_compareOutcomes_Lancet_2006.pdf)WHO global survey on maternal and

               perinatal health in Latin America; Jos� Villar, *et al* [**2005**](http://docs.google.com/CS-SVD_compareOutcomes_Lancet_2006.pdf) --

**Findings:** We obtained data for 97 095 of 106,546 deliveries (91% coverage). The median rate of caesarean delivery was **33%** (quartile range 24�43), with the highest rates of caesarean delivery noted in private hospitals (**51%)** [43�57]. Institution-specific rates of caesarean delivery were affected by primiparity, previous caesarean delivery, and institutional complexity.

**Rate of caesarean delivery was positively associated with postpartum antibiotic treatment and** **severe maternal morbidity and mortality**, even after adjustment for risk factors. Increase in the rate of caesarean delivery was associated with an **increase in fetal mortality rates** and higher numbers of babies admitted to intensive care for 7 days or longer even after adjustment for preterm delivery. **Rates of preterm delivery and neonatal mortality both rose at rates of caesarean delivery of between 10% and 20%**.

**Interpretation: High rates of caesarean delivery do not necessarily indicate better perinatal care and can be associated with harm.**

**D-5**  [Is planned cesarean childbirth a safe alternative?](http://docs.google.com/Citations_Studies_2008/PCS_IsItSafe_CMA_07.html) by B. Anthony Armson, MD,

              Canadian Medical Assoc. Journal Feb 13, 2007

               "In the planned cesarean group, the **overall risk of severe maternal morbidity was 3.1 times that in the planned vaginal delivery group**, including increased risks of postpartum cardiac arrest, wound hematoma, hysterectomy, major puerperal infection, anesthetic complications, venous thrombo-embolism and hemorrhage requiring hysterectomy.  The absolute increases in severe maternal morbidity rates with planned cesarean birth, however, were small."  page one, 2nd column

**D-6 **   [Elective Cesarean Section: An Acceptable Alternative to Vaginal Delivery?](http://docs.google.com/Citations_Studies_2008/Elec%20CS%20Medscape_Bernstein_%2002.html)

                        Peter S. Bernstein, MD, MPH; Medscape Ob/Gyn & Women's Health -- Posted Web Site 09/16/2002

                        "To suggest that performing an elective cesarean delivery in a low-risk patient will avert intrapartum fetal injury

         is very misleading. These outcomes are rare, even in higher-risk women. Indeed, they are **so rare in women without any**

**identifiable risk factors that an absurd number of cesarean deliveries** would need to be performed **to avert even**

**1 of these poor outcomes**. .......  There may be **no legal liability to the physician who performed the patient's first**

**cesarean section 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**.

**D-7**  [Chilean women�s preferences regarding mode of delivery: which do they prefer and why?](http://docs.google.com/Citations_Studies_2008/ChileanWomen-Don%27t%20prefer_CS_2006.html)

             Correspondence: Dr AB Caughey, Department of Obstetrics, Gynecology, and Reproductive Sciences,

             University of California, San Francisco, 505 Parnassus Avenue, PO Box 0132, San Francisco, CA 94143,

**RCOG 2006 BJOG An International Journal of Obstetrics and Gynaecology**  --

          Editor's Note: this study demonstrates that women overwhelming choose vaginal birth. It also show that

             the disproportionate increase in CSs, especially among private patients, is primarily a reflection of

            "**physician preference**" for surgical delivery (often influencing women during a long or painful labor)

**D-8**   [Patient-choice vaginal delivery? Annals of Family Medicine 01-MAY-06](http://docs.google.com/Citations_Studies_2008/Patient-choiceVaginalDel_AnnalFamilyMed_06.html)

        Patient-choice cesarean delivery is increasing in the United States. As physicians who advocate for women's right to choose among a variety of medical options, we are pleased at the emphasis on preserving women's medical choices. We are, however, **perplexed at the narrowness of the choice. In recent years we have seen a decline in women's choices for vaginal birth as vaginal birth after cesarean (VBAC) becomes less available** and vaginal breech birth is rarely performed. (4,5) The question of patient-choice cesarean delivery asks only whether a woman should have the right to choose a cesarean delivery in the absence of a medical indication. **A woman's right to choose a vaginal delivery is not addressed.**

**Why is cesarean delivery and not vaginal delivery framed in the language of choice?** We contrast ... explain the **importance of considering the effects of a primary elective cesarean delivery on maternal and neonatal outcomes of subsequent pregnancies, and describe the potential long-term implications** of the growing acceptance of patient-choice cesarean delivery.

****   [Cesarean Delivery on Maternal Request: Wise Use of Finite Resources? A View from the Trenches](http://docs.google.com/Citations_Studies_2008/ElecCS-economics_Drusin-2006.html)";

                    Maurice L. Druzin, MD, et al - 2006 -- Economic argument against routine elective Cesarean

                    by **Chief of Ob-Gyn at Stanford University Hospital, California**

**"**The **medical impact of a rising cesarean section rate** on both short- and long-term maternal and neonatal complications, and the **associated costs of these complications**, must be taken into account. A recent study showed that the **incidence of placental accreta is** **increasing in conjunction with the rising cesarean section rate**.11 Placental implantation abnormalities such as placenta accreta add **cost to the health care system** because of the increased intervention required for optimizing outcome. The use of MRI, Interventional Radiology, blood transfusions, hysterectomy, and intensive care admissions, all interventions which are increasingly employed in cases of placenta accreta, **dramatically increase the cost of care**.

......there are **finite resources** at every level for society. We have **an obligation** to review the expenditure of health care dollar **to ensure optimal utilization for the overall societal good**. As non-economist practicing obstetricians, it strikes us that we are **increasingly being asked to embrace maternal request cesarean section**. In our opinion, the available **scientific data do not justify this practice**, and our �from the trenches�  **economic assessment suggests the same**."

**D-9**  [Cesarean Delivery: Background, Trends, and Epidemiology](http://docs.google.com/Citations_Studies_2008/Menacker%20Declercq%20CS%20trends%20and%20request.html)**; by Fay Menacker, Dr.PH, CPNP,**

**Eugene Declercq, PhD,� and Marian F. Macdorman, PhD**

".... **markedly different practice recommendations regarding cesarean delivery** from the American and International obstetrical groups. The **American College of Obstetricians and Gynecologists** (ACOG) states that:

**In the absence of significant data on the risks and benefits of cesarean delivery** . . . if the physician believes that cesarean delivery promotes the overall health and welfare of the woman and her fetus more than vaginal birth, he or she **is ethically justified in performing a cesarean delivery**.

In contrast, the I**nternational Federation of Gynecology and Obstetrics** (FIGO) states that:

**At present, because hard evidence of net benefit does not exist, performing cesarean delivery for non-medical reasons is not ethically justified.**

**D-10**   [Childbirth Pelvic Floor Will a planned c-section prevent problems?](http://docs.google.com/Citations_Studies_2008/CB-PelvicFloor_MKleinMD_07.html)**[No, it won't!]**

Dr Michael Klien, MD, CCFP, FAAP, Neonatal-Perinatal), Emeritus Professor of Family Practice and

                    Pediatrics at University of British Columbia and Children's and Women's Health Centre of

                    British Columbia, Canada; **F a m i l y H e a l t h ... SPRING 2007**

**D-11** [Elective cesarean section to prevent anal incontinence and brachial plexus injuries](http://docs.google.com/Citations_Studies_2008/ElecCS_Challenge_incontinence_07.html)

             associated with macrosomia�a decision analysis International Uro-gynecology Journal (2007)

One of the most fascinating aspects of this paper is that even though they looked at this as a strategy to prevent urinary incontinence, **they could not show that this would significantly reduce the incidence of urinary incontinence. This together with several other large epidemiologic studies are starting to cast doubt on the strategy of elective cesarean section to prevent urinary incontinence**.

**D-12**  [Cesarean a Risk Factor for Emergent Hysterectomy](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/CS%2015%20Xs%20Emergent%20Hysterectomy%2003.pdf); Obstet Gynecol 2003 Jul; 102

**Bottom Line**: Thirteen times higher rate of emergency hysterectomy during or within

                    14 days of Cesarean delivery

**D-13** [Post-cesarean delivery adhesions associated with delayed delivery of infant](http://docs.google.com/Citations_Studies_2008/Cesareans_Adhesions_ObGynJournal_05.html)

                American Journal of Obstetrics and Gynecology Volume 196, Issue 5, May 2007,

                    Presented at the Armed Forces District Annual Meeting of the **American College of Obstetricians**

**and Gynecologists, Seattle, WA, Oct. 31-Nov. 4, 2005.**

**D-14** [Association of caesarean delivery for first birth with placenta praevia and placental abruption](http://docs.google.com/Citations_Studies_2008/CS_previa_abrupton_07.html)

[in second pregnancy](http://docs.google.com/Citations_Studies_2008/CS_previa_abrupton_07.html) -- **The Authors Journal compilation RCOG 2007=**

**BJOG - An International Journal of Obstetrics & Gynaecology**

**D-15**   Routine use of elective CS for breech --  [Not safer and not cheaper!](http://docs.google.com/Citations_Studies_2008/CMAJ_NotSaferNotCheaper_06.html)  -- Letters to Editor

                    by Michael Klein, MD; Centre for Community Child Health Research, BC Child and Family Research,

                    Institute, Vancouver, BC� 2006 CMA Media Inc.

**D-16**   [Voluntary C-Section Results in More Baby Deaths](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/Voluntary%20CS%20Up%20perinatal%20death_Dec06.pdf)**;** New Your Times report, September 06, 2006

                     on paper published in *Birth: Issues in Perinatal Care* 2006; Dr M. Malloy *et al*

**D-17** CNN report: [Cesarean Birth Triples Maternal Death Risk](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/CNN_Triple_MatDeath_ECS_Aug2006.pdf) �  original paper �**Postpartum Maternal**

**Mortality and Cesarean Delivery**� by Catherine Deneux-Tharaux, MD, MPH, *et al*; OBSTETRICS &

                    GYNECOLOGY VOL. 108, NO. 3, PART 1, SEPTEMBER 2006

**D-18** [Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term](http://docs.google.com/Citations_Studies_2008/CS%20risks%20CMAJ_07.html)**;** Shiliang Liu, *et al*; for the **Maternal Health Study Group of the Canadian Perinatal Surveillance System**  **CMAJ � February 13, 2007 � 176(4)**

**D-19** [Maternal deaths after elective cesarean section for breech presentation](http://docs.google.com/Citations_Studies_2008/MaternalDeaths_Elec-CS_Breech_07.html) in the Netherlands

                 Elective cesarean section does not guarantee the improved outcome of the child, but may increase risks

                     for the mother, compared to vaginal delivery.   **(2007)**

**D-20** \*\*\*  [Cesarean Section on Request at 39 Weeks:](http://docs.google.com/Citations_Studies_2008/CS%20and%20encephalopathy%20seminars.html) **Impact on Shoulder Dystocia, Fetal Trauma,**

**Neonatal Encephalopathy, and Intrauterine Fetal Demise:**

Gary D. V. Hankins, MD, *et al*; The University of Texas Medical Branch, Department of Obstetrics and

                    Gynecology, Division of Maternal Fetal Medicine, Galveston, TX. **2006 Elsevier Inc.**

**\*\*\* Editor's Note:  I found his thinking and conclusions to be at odds with the broader scientific consensus**

**D-21**   [Cases Revive Childbirth Rights Debate](http://docs.google.com/Political_Action_2006/Cases%20Revive%20Childbirth%20Rights%20Debate.pdf) **-- By DAVID B. CARUSO -- The Associated Press --**

May 20, **2004** Newspaper article about **hospital who sought a court-ordered C-section** for large baby

                    -- 7th time mom, with six previously successful vaginal births of babies weighing

**D-22**   [C-Section Lawsuit A Plaintiff�s Verdict: Meador vs Stahler & Gheridian](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/CSlawsuitVBAC_jan07.pdf); (and wins!)

                    for unwanted and unnecessary cesarean surgery;  [www.forensic-psych.com](http://www.forensic-psych.com/),

**D-23** [Insurance Companies Rejects Women with History of Cesarean](http://docs.google.com/Political_Action_2006/PrevCS_Insurance-Refuse_ICAN_08.pdf)**,**

**Some Require Surgical Sterilization for Coverage (2008)**

**--> gives new imperative to avoid medically unnecessary Cesarean**

**D-24** [A letter from a hospital explaining why they banned VBAC March 24, 2008](http://docs.google.com/Political_Action_2006/HospLtter_NoVBAC_Mar_08.pdf)

**from web site--> VBACfacts.com**

**Editor's Note:** this reads like a sexist spoof, but is all too serious. In addition, its obstetrician-author badly misrepresents the perinatal mortality statistics, claiming there is one fetal/neonatal death for every 200 VBAC labors, when the most recent and rigorous scientific studies identify a PNM rate of only one per **2,000**, which is approximately the same risk as a primigravida (1st time mother)

**D-25** [Navigational grid for](http://www.sciencebasedbirth.com/CEO%20SSB/Synopsis_CEO_mission_2004.htm#scientific%20Literature)  [Scientific Literature](http://www.sciencebasedbirth.com/CEO%20SSB/Synopsis_CEO_mission_2004.htm#scientific%20Literature) on medical & physiological management of childbirth

                   -- includes [**Step by step photos of Cesarean surgery**](http://www.sciencebasedbirth.com/imagesTextBk2004/CS_PhotoSeries_Page1.htm) and [**Photos ~ Forceps & episiotomy**](http://www.sciencebasedbirth.com/imagesTextBk2004/Photo_EpisForceps1.htm)

                        [editor's Note -- these sources, on average, are five or more years old. This actually tells the reader

                        that the 'science' has been out there for a very long time and is being systematically ignored by ACOG.]

D-26 Five 'YouTube' videos that demonstrate the reality of Cesarean surgery and just how remarkably different surgical delivery is from normal or physiological childbirth

**Vaginal Births:** 1. [Brown Medical School teaching vaginal birth techniques](http://www.youtube.com/watch?v=O1wJ6ksDUi4&feature=email) 2. [Vaginal birth conducted as a surgical procedure](http://www.youtube.com/watch?v=XNSrV-EB_sQ&feature=email)  3. [Labor and birth w/ episiotomy in Japan -- moved to del room, full-tilt surgical procedure](http://www.youtube.com/watch?v=jxZpzFRTHrQ&feature=email)    4.  [El Parto -- vaginal del by OB](http://www.youtube.com/watch?v=24NTQq8LvZA&feature=email)   5. [El Parto #2 vag del with episiotomy](http://www.youtube.com/watch?v=j1nNanmrAhE&NR=1)

**Cesarean Deliveries:** 4.[C-section surgery ~ Some where in the EU](http://www.youtube.com/watch?v=xKNeIiC5Jyc&feature=email)  6.  [Cesarean birth of Matheus @ Hospital Sta Rita Assis Chateaubriand - PR](http://www.youtube.com/watch?v=yRRcAIRAyEM&feature=email)  6.  [Parto Marilia & Julia - extraction of baby](http://www.youtube.com/watch?v=y-ZgZRiL8YI&feature=email) 7.  [Parto Da Geordany -- comprehensive video of elective CS](http://www.youtube.com/watch?v=wTOlFFW7DNk&feature=email)



"[EFM as a Public Health Screening Program: The Arithmetic of Failure](http://docs.google.com/Citations_Studies_2008/EFH-PublicHealthFailure_DrDavidGrimes_Dec2010.htm)" ~ by Dr David Grimes

**Electronic fetal monitoring has failed as a public health screening program.** **Nevertheless, most of the**

**four million low-risk women giving birth in the United States each year continue to undergo this screening**.

 [The false association](http://docs.google.com/Political_Action_2006/False_assoc_EFM-CS-prev-CP_08.htm) between the routine use of continuous of electronic fetal monitoring (EFM) and high rates of Cesarean Section as a strategy to prevent Cerebral Palsy and other neurological damage -- citations from (

[a) Am. College of Obstetrician & Gynecologists (ACOG) *Task Force on Neonatal Encephalopathy & Cerebral Palsy,* 2003

[b) September 15, 2003 edition of *Ob.Gyn.News;*  [c] and August 15, 2002 report in *Ob.Gyn.News*.

[Cesareans not safe or effective for preventing pelvic problems](http://docs.google.com/Political_Action_2006/CS_Incontinence_faith_Jun08.htm): 

          Having identified that the �prophylactic� use of Cesarean is unable to prevent cerebral palsy in babies, elective C-section is often promoted as a prophylactic procedure whose value lies in reducing pelvic floor problems later in the woman�s life. However, reputable research also does not support the use of elective Cesarean surgery as either a safe or a reliable method to achieve this goal.

          In an article entitled �[*Elective Cesarean Section: An Acceptable Alternative to Vaginal Delivery?*](http://www.sciencebasedbirth.com/temporary02/CEO%20synop%20politics_of_cesarean_2004.htm#Dr%20Peter%20Bernstein,)�, Dr Peter Bernstein, MD, MPH, Associate Professor of Clinical Obstetrics & Gynecology and Women's Health at the Albert Einstein College of Medicine, **reported on the failure of the obstetrical profession to practice evidence-based medicine as it applies to this topic**.  Addressing the popular notion that pelvic floor damage and incontinence were the inevitable result of normal birth (to which cesarean surgery was the proposed remedy), Dr Bernstein observed:

�...these adverse side effects may be **more the result of *how* current obstetrics manages the second [pushing] stage 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 [lying flat on the back] with encouragement from birth attendants to shorten the second stage with the Valsalva maneuver [prolonged breath-holding], as is commonly practiced in developed countries, contributes significantly to the problem.**�  [Click here for rest of article](http://docs.google.com/Political_Action_2006/CS_Incontinence_faith_Jun08.htm)

**SECTION E --**

     Political Issues,  by ACOG Campaign to Eliminate Professional Mfry & PHB

  **E-1** [Marginalizing of Nurse Midwifery](http://docs.google.com/Marginalizing_NurseMfry_May07.pdf)

           In a hurry?

                  Just want to cut to the chase?

                          Want to copy text for a quote?

                                    Try  **E-2**  [Annotated Excerpts](http://docs.google.com/Citations_Studies_2008/Marginalizing-NMfry_Excerpts_May07-C.pdf) of the Marginalization of Nurse Midwifery

  **E-3**  [Choice in Planning and Experiencing Childbirth](http://docs.google.com/Political_Action_2006/AMA-Jour-Ethics_NMfry-close-NYC_Sept04.doc) *AMA Journal of Ethics ~ Virtual Mentor.*  [September 2004](http://virtualmentor.ama-assn.org/2004/09/toc-0409.html), Volume 6, Number 9. Policy Forum Another paper on marginalizing nurse midwifery

 **E-4**  [Dec 22, 2006 - Letter to ACOG from Childbirth Connection --](http://docs.google.com/Political_Action_2006/MCA_Lttr_ACOG_PolicyPHB_07.pdf)

                                       a formal objection to ACOG's press statements about planned home birth

**E-4-b**   [**ACOG Place of Birth Policies  ~ Limit Women's Choices contrary to the Evidence**](http://docs.google.com/Political_Action_2006/ACOG_Policies-PHB-LimitWomen_Excerpts-07.pdf)

**From Childbirth Connections**

**** **E-5** [1996 Kansas Supreme Court Decision](http://docs.google.com/college_of_midiwves01/kansascourt.htm)   -- **Ruling that Midwifery is Not the Practice of Medicine**

** E-6**  [Mass ACOG Fellows  --> SB 2636, an Act Relative to a Board of Registration in Midwifery;](http://docs.google.com/Political_Action_2006/ACOG-Bulletin_Mass%20MfryLic_SB1251_May08.pdf)

**28 May 2008  From: Erin E. Tracy, M.D., M.P.H. (MA ACOG Legislative Committee Chair)**

** E-7**  [ACOG Document **-->**](http://docs.google.com/Political_Action_2006/ACOG_Insider_Midwifery-Review_2007.pdf)   [**�Lay� Midwives & Home Birth:**](http://docs.google.com/Political_Action_2006/ACOG_Insider_Midwifery-Review_2007.pdf)

**Troubling Trends in State Legislation:**

**■ Home birth bills on the rise.**

**■ Least qualified direct-entry midwives gaining licensure.**

**■ The midwives� advantage.**

**■ ACOG on the defensive**

** E-8**  [Birth Environments 1992](http://docs.google.com/Political_Action_2006/BirthEnvironment_HospEconomics_1992.pdf)   **A- Economics of  hospital obstetrical departments**

**E-9**   [Docs become Mr. Hydes as lobbyists](http://docs.google.com/Political_Action_2006/TheTennessean_MedMalScam_06.pdf) **-- LARRY DAUGHTREY -- April 23, 2006**

**Newspaper report -- Tennessean revealing Med-Mal Insurance as a money maker for investors**

Here is an excerpt from a newspaper article on a weekly lobbying campaign by physicians in Tennessee. They were hoping to get changes in the law that would have benefited the med-mal carriers and supposedly reduced their premiums. **Apparently med-mal companies make money by investing the premiums in the stock market that are left over after they pay out the annual claims**.

 �Was there a crisis to begin with? State regulators didn't think so. A little-noticed report for the year 2004, issued last October, had some startling findings.

During that year, **only six medical malpractice cases reached juries in Tennessee**, with **awards totaling $1.9 million**. Insurance companies  **settled 444 before trial** at a cost of $108 million, with **an average settlement of $45,904**.

Insurance  **premiums charged that year totaled $327 million**.

The dominant medical **malpractice insurance firm in Tennessee is a mutual company owned by the doctors themselves, meaning that it returns dividends to its members**. It has **$765 million in reserves**. Tennessee ranks in the lowest third of the states in malpractice premiums.�

    Obstetrician Supervision of Midwives & California-specific Documents

 **E-10**   [Medical Board of California -- Robert del Junco, M.D.](http://docs.google.com/Political_Action_2006/Dr-delJuco-misuse_PhyExtenders_1993.pdf) - **Chair**  (former president of the MBC)

**Status Report:  Health policy and Resources Task force**

**Topic:** ... dubious billing practices by physicians who charge for a doctor�s office visit,

                                          even when the patients is cared for by a nurse practitioner and is never seen by the doctor

 **E-11** [ObGynNews Sept15, 1993](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/ObGynNews_Sept15_1993.pdf)

 Anti-Midiwfery/PHB statements by California Malpractice carriers and lobbying organizations

**E-12**  [NorCal Mutual Newsletter 1978](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/NorCal_MuturalNews_1978.pdf);

**E-13**    [NorCal letter 05-18-99;](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/NorCal_Letter_May99_3pgs.pdf)

**E-14**     [CAPLI letter 2005](http://docs.google.com/MfryAdvisoryCouncil_Feb2007/CAPLI_letter_2004.pdf)

 **E- 15** [Why and How to Reverse the 1976 Bowland Decision](http://docs.google.com/Faith_Manuscripts_2005/Why_%26_How_Reverse_Bowland_April06.html) - 2006 -- in depth exploration of the fatally flawed legal theories use in an attempt to by organized medicine enforce their monopoly over normal childbirth services by criminalizing non-nurse midwives, while restricting the independent practice of CNMs through mandatory obstetrician supervision laws.

[Long but well worth the effort -- **this is one of the best essays on the historical and legal aspects** of midwifery and obstetrics and full of good quotes.]

 **E17**  [Winning a Case Against Powerful Medical Society](http://docs.google.com/Citations_Studies_2008/AG-Opinion_AgainstOrgMed_May08.html)**:** Settlement Announced in Landmark

                        Investigation of Lyme Disease Diagnosis and Treatment Guidelines Patients' Rights Groups Applaud

**Connecticut Attorney General Blumenthal's Anti-trust decision (2008)**

Editor's Note on E-17: The legal theory successfully advanced in this care would also apply to mandated obstetrician supervision of midwives as a tool of political suppression. This unfair business practice and restraint of trade **masquerades as science-based issue of safety but in fact, has nothing to do with safety**. It has everything to do with enforcing a monopoly over childbirth services by eliminating the independent practice of midwifery. By controlling the potential pool of care providers, healthy women who do not need or want an obstetrically managed labor, are forced to accept medicalized childbirth.

As identified by the outcome stats published in the BMJ (and dozens of similar studies) PHB by independently practicing midwives (i.e. no obstetrical supervision) had identical maternal and perinatal mortality rates, with a 2 to ten-fold reduction in medical and surgical interventions for the mother and a 4% Cesarean section rate, which is approximately 7 1/2 times less than the national C-section rate for hospital-based obstetrics.

E -18 [Press Release from the The Big Push for Midwives](http://docs.google.com/MfryControversies_2006/9-11-2009_PushNews_Physicians_Anti-Midwife-antiPHB_Smear_Campaign09.pdf) -- rebuttal to ACOG's

          anti-midwife, anti-PHB segment on the September 11, 2009 Today show

Judging a System by its Results

|  |  |  |
| --- | --- | --- |
| **Ultimately, a maternity care system is judged by its results**  **-- the number of mothers and babies who graduate from its ministration as healthy,  or healthier, than when they started.** |  |  |

Medicalizing healthy women makes normal childbirth unnecessarily and artificially dangerous and is unproductively expensive. Our current system of routine obstetrical intervention for healthy women must be reevaluated and reformed. But unlike many of the problems facing us in the 21st century that defied our best efforts � curing cancer, ending terrorism, reversing global warming, figuring out how to afford healthcare, etc.,� we know what to do about this problem. The scientific literature clearly demonstrates that physiological management is the safer and most cost-effective form of care for a healthy population.

         For many centuries, the normal, non-surgical care of pregnancy and normal birth has been called �**maternity� care**. The origin of this word is �maternal� and describes care organized around the needs of the mother and her strong desire to protect her unborn or newborn baby. **One small step towards a more functional system would be to use the term maternity care instead of  �obstetrical� when providing care to healthy women during a normal pregnancy or childbirth.** This simple correction would help everyone realize that childbearing is primarily about the mother and baby and not primarily about the *professions* or *professionals* that provide that care.

                        Efforts to rehabilitate our maternity care system must start by listening to childbearing women and their families as a class of *experts in the maternity experience*. Because physiological management has never been a part of obstetrical education in the US, medical educators must learn and teach the principles of physiological management to med students.

**A newly formulated national maternity care policy would integrate physiological principles with the best advances in obstetrical medicine to create a single, evidence-based standard for all healthy women**. All categories of birth attendants would use these methods when providing care to healthy women with normal pregnancies. Only then will family practice physicians, obstetricians and professional midwives be able to enjoy a mutually respectful, non-controversial relationship. Under this logical system, **the appropriate form of care for any individual mother-to-be (physiological vs. medical) would be determined by the health status of the childbearing woman and her unborn baby, in conjunction with the mother�s stated preferences, rather than by the occupational status of the care provider (physician, obstetrician, midwife).** At present, *who* the woman seeks care *from*  (physician/obstetrician vs. midwife) determines *how* she is cared for. This is illogical.

         I**t�s inappropriate to use a surgical billing code for normal spontaneous childbirth**. A professional billing code must be configured for physiologically-based care which encompasses the entire intrapartum period as a continuum. This would f**airly reimburse professional birth attendants for the time they spend** supporting the normal process of labor, birth and the immediate postpartum/neonatal period.  **Prevention must be valued equally with intervention as the proper role of the professional maternity care provider**. Methods that reduce the need for medical intervention and surgical procedures benefit the childbearing woman and her family, third party payers, the economy, the environment and the goals of a humane society.

The question is simply this: How much longer will we be content to use an expensive, pathologically-oriented and outmoded 19th century system for our healthy 21st century population?

[**Return to College of Midwives' Home Page**](http://docs.google.com/index.htm)

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