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| Responce by Citizens for Midwiferyto the Good Morning America’sTues. June 20 program with Diane Sawyer |
| "Patient Choice" (medically unnecessary) elective c-sectionsto avoid the infrequent and non-fatal complicationsof normal childbirth,with Dr. Marsden Wagner and Dr. Benson Harer,   presidentof the American College of Obstetricians and Gynecologists |

Susan Hodges, President

Citizens for Midwifery

1800CfM4880 (eastern time)

[www.cfmidwifery.org](http://www.cfmidwifery.org/)

Citizens for Midwifery, Inc. is a tax-exempt organization of people who want to promote the Midwifery Model of Care through public education and grassroots actions. Find more information about CfM and the Midwifery Model of Care on the web site.

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Dear Diane Sawyer,

I watched your segment on "elective" cesarean sections (Dr. Harer and Dr. Wagner debate on "Good Morning America" 6/20) with great interest.

As President of Citizens for Midwifery, a national, nonprofit consumer organization, I have been following the recent sudden spate of news articles promoting "elective" or "patient choice" cesarean sections. In all of them the concept has originated from obstetricians, not the public, and the articles have included the same arguments Dr. Harer presented.

While c-sections and other medical interventions can be lifesaving in a very small percentage of births, obstetricians already perform many, many unnecessary cesareans and other interventions. Many of these have been shown to be harmful and/or ineffective but are still the standard of care (Enkin et al, A Guide to Effective Care in Pregnancy and Childbirth 2nd edition (February 1995) Oxford Univ Press, a book based on the acclaimed Oxford database of perinatal trials).

The rate of c-sections that can be defended in any way on medical grounds is limited. But if obstetricians can persuade the public that vaginal birth is "dangerous" and c-sections are "better for baby" in spite of the facts, the market for "patient choice" c-sections could be huge. Obstetricians have great incentive to promote unnecessary c-sections in the manipulative guise of "patient choice." C-sections can be conveniently scheduled, and one obstetrician can perform (and be paid for) many c-sections in the same time it would take to "manage" a smaller number of vaginal births. In addition, more c-sections would help keep hospital facilities occupied with paying patients.

Please read below my brief analysis of the main arguments being put forward. When you continue the debate, I urge you to consider including a well-informed woman, one who is neither an obstetrician nor a midwife. I would highly recommend that you contact Henci Goer, author of the excellent research-based book The Thinking Woman's Guide to a Better Birth (1999, The Berkeley Publishing Group, New York). She is a medical researcher and writer, a childbirth educator, an articulate speaker, and neither a midwife nor an obstetrician. You can reach her at <wegoers@aol.com>.

Please feel free to contact me.

Sincerely,

Susan Hodges, President

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A brief analysis of the main arguments put forward to promote "elective" or "patient choice" cesarean sections

In addition to the fact that the research data on risks to babies from c-sections make a lie out of Dr. Harer's contention that c-section is safer for baby, as Dr. Wagner pointed out, there are several other serious problems with the position touted by Dr. Harer and other obstetricians.

1. In making their claims, especially the scare stories about the damaging effects of "vaginal birth" (later onset of incontinence problems is all of a sudden a concern), the obstetricians are not differentiating between vaginal births which have been subject to practices and interventions typical of medically-managed hospital births, and vaginal births without interventions, typical of midwife-attended out-of-hospital births. Lumping together all vaginal births and then drawing conclusions without accounting for the effects of interventions is just plain inexcusably unscientific.

In the vast majority of vaginal births in this country laboring women are subject to many practices and interventions which themselves can and often do cause both long and short term complications. One example is the use of oxytocin to stimulate labor (which is on the rise according to the CDC, oxytocin use doubled between 1989 and 1997 to 17% of births). Being subject to oxytocin stimulation in just one labor nearly doubles the mother's risk of later stress incontinence, and oxytocin in two labors triples her chances. Other risk factors include extensive episiotomy (cutting of the perineum, still performed frequently during delivery) and operative

vaginal delivery (forceps and vacuum extraction 10% of vaginal births as of 1997). Not waiting till the mother is ready to push, and then exhorting her to hold her breath and PUSH! also puts unnatural stress on the pelvic floor, as does being in the typical semi-lithotomy position.

Vaginal birth> by itself is not the problem; standard medical practices and interventions are the main problem. However, obstetricians generally have no training, no experience and no intellectual structure for even recognize this intervention problem, let alone to offer women the setting, the skills and the emotional and physical support which are very helpful if not essential for a woman to give birth vaginally without medical interventions over an intact perineum (and with little or no "pelvic floor damage" that can lead to later incontinence problems).

2. There is a fundamental conflict of interests in this debate. The only people promoting the idea of "patient choice" cesareans are obstetricians, who have the most to gain from more cesarean sections � c-sections are more convenient, they take less time, and in many cases the obstetricians are paid more for them. Most of the obstetricians promoting "patient choice" are men who never have and never will give birth. Obstetricians have specialized not in normal childbirth but in the pathology of childbirth and are trained only in the narrow, rigid, controlling and mechanistic medical model of care which views even normal pregnancy and birth as a disease. You would do well to advise women to carefully seek out and study childbirth information from unbiased sources, ie, from authorities who are not obstetricians.

3. Finally, it is astonishing (and yet a clever and manipulative public relations strategy) for obstetricians suddenly to be claiming that women are intelligent and should make up their own minds on whether or not to have a c-section, when the obstetrics profession has a long, patronizing and formidable history of denying choices to women. Historically, the obstetrical profession to my knowledge has never offered women any meaningful choices, only the appearance of choices where the obstetrician stands to gain money, power or both. For example, the obstetrical community continues its long-standing and steadfast position that all births should be in hospitals, that all midwives should be controlled by physicians, and that midwife-attended out-of-hospital birth is dangerous, even though no published study has ever shown the hospital to be the safest place to have a baby, and every published study has shown planned, midwife-attended births to be at least as safe as doctor-managed hospital births. Ironically, midwives, especially for births outside the hospital, have very low rates for c-sections (actually, very low rates of referral for c-sections, as midwives do not perform them), because they are skilled in very low-risk non-interventive techniques for supporting and encouraging women through labor. Midwives do not use drugs for pain or for labor stimulation, almost never cut episiotomies, help women ease their babies out without straining and tearing, etc. � all of which avoid causes of later incontinence problems and minimize the risk of complications leading to c-sections. Yet the obstetrical profession, through legislation and lobbying, investigations of midwives,restrictive rules and regulations, unwillingness to work with midwives or respect women's choices, and other means, continues to obstruct and prevent women's access to the Midwifery Model of Care and midwife-attended out-of-hospital birth � obstetricians apparently do not want women to have this choice presumably because they would risk losing business and losing credibility for expensive, interventive medical childbirth care.

This is just a brief discussion of a few of the most important aspects of this "debate" so far. There is substantial statistical information refuting the position of these obstetricians. Ask the obstetricians for citations of published studies showing that vaginal birth by itself, not their interventions, is the problem � you will find they can't produce the evidence. Please help your viewers to see that the "patient choice" c-section propaganda is like the emperor with no clothes in the well known children's story.

Comments provided by Susan Hodges, President, Citizens for Midwifery

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