

The Ties That Bind
How Belief Creates Birth Realities
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There is a story told of a baby elephant in Tibet¹, tied about the ankle with a rope. The rope would not hold an adult elephant, but it holds the baby tight even as it struggles to free itself. The baby resigns itself to the fact that it cannot move outside of the parameters of the rope, no matter how hard it tries.

Eventually, the elephant reaches adulthood, the same little rope about his ankle. Now, little effort would be required to snap the rope and walk away...but the elephant doesn't even bother to try. He is bound only by his 'belief' that he is unable to escape, which is just as effective as his captors.

Women giving birth today have more options than ever before, yet perceive very few. Information is available in unprecedented quantities at the touch of a fingertip, yet erroneous *beliefs* impact decision making more than cold, hard *facts*.

Women *believe* that birth is a dangerous medical event.
The *fact* is that normal birth is safer than many things we do each day without a thought.²

Women *believe* that US technology makes birth safe.
The *fact* is that birth is much safer in countries where technology is more appropriately utilized.³

Worse, often women are not making decisions at all. Like the elephant that cannot conceive that he has the power to walk away, women simply do not see the options before them.

A mother called me regarding private childbirth classes. During the course of the discussion, she explained that she wasn't even sure the classes would help her, as she was planning a VBAC⁴ and doubted it would 'work'. Further discussion revealed that her doctor was insisting on certain 'conditions' in order to 'attempt' this VBAC.

¹ This universally understood story has many variations, with different locations, and even different animals.

² Mortality statistics for motor vehicle accidents, heart disease, unintentional injury, cancer, and HIV, among other things people put themselves at risk for can be found at www.cdc.gov/nchs

³ The US is rated 27th in the world for infant mortality. Child Health USA 2001, Maternal Child Health Bureau, Health Resources and Services, US Dept. of Health and Human Services, p. 22
The US is rated 13th in the world for maternal mortality. State of the World's Mothers 2000, Save the Children 2000 p. 25

⁴ Vaginal birth after cesarean

- The mother would be induced if she went ‘over due’, via an ultrasound determination⁵
- The mother would be induced if her baby got ‘too big’, via an ultrasound estimation⁶
- The mother must deliver between 7 am and 5 pm when an anesthesiologist would be on hand. If that looked unlikely, induction or augmentation would be required. If she did not dilate steadily and quickly (ala Friedman’s Curve) she would be augmented with pitocin or cytotec. If she were still laboring near the end of her given time frame, surgery would be inevitable.⁷
- The mother must labor with an epidural.⁸

The reason for these restrictions was that ACOG⁹ had issued new guidelines for VBAC, supposedly from a study that supposedly proved VBAC was unsafe.¹⁰

However, what they study showed was that *obstetrically managed VBAC* was unsafe. The factors that made VBAC unsafe were mainly...hold on to your seat...*pharmaceutical induction agents that are **known to cause uterine rupture in non-scared uteri***. In other words, any woman in labor who gets them, not just VBAC mothers. Instead of investigating the drugs, not FDA approved for non-medical indications, the recommendation became to put restrictions on VBAC that bring about the very conditions that are singular to *the drug/VBAC combination*, not the *VBAC itself*. That logic is just lost on me, but it’s beside the point, anyway.

The story of the elephant I began this piece with doesn’t parallel the illogic of ACOG, it parallels the mother who contacted me. She was quite distraught that she probably wouldn’t be able to meet all of these conditions. She’s right. She’s got as much control over them as she has over the tides, the moon or the sun.

She asked if I thought she had a bad doctor. She asked what I thought about the hospital policies. She asked if she should change hospitals or doctors. None of these are my call to make, even if I knew her or her doctor, which I didn’t. I told her I thought she had some tough decisions to make. As a childbirth educator, I could provide her with the information she needed to weigh in order to make a sound decision, which I did. I gave her several book recommendations and links to studies showing the conditions she was

⁵ Ultrasound is only accurate to within 2 weeks either side of an estimated due date. Only about 5% of babies are actually born on their ‘due date’. See: <http://www.birthsource.com/articlefile/Article86.html>

⁶ Ultrasound is no more accurate than an educated guess at fetal weight. J. Reprod. Med. 2002 Mar.;47(3):194-8 *Clinical and patient estimation of fetal weight vs. ultrasound estimation*. Baum JD, Gussman D, Wirth JC 3rd. It is only accurate to 2 lb. either side of the actual weight. Considering that most obstetricians consider a normal 8 lb. baby to be ‘too big’, if they induce because U/S says the baby is nearing 8 lb., the baby could really be 5 lb. 15 oz.

⁷ <http://www.obgyn-wolfson.org.il/Content/Articles/ArticlePDF/ArticlePDF655.pdf>

<http://www.midwiferytoday.com/enews/enews0326.asp>

⁸ <http://www.childbirth.org/articles/episec.html>

⁹ American College of Obstetricians and Gynecologists. Not a college, but a trade organization for Obs.

¹⁰ <http://www.hencigoer.com/articles/>

being asked to meet were not only impossible, but flew in the face of science and plain old common sense.

I reminded her that the criteria¹¹ for making sound decisions must include determining if the choice she was being asked to make was based on facts (it wasn't), if it was in her and her baby's best interest (it wasn't), or if it would improve her experience (it wouldn't)

I heard from her again at a later date. She had read some of the material and she was getting anxious about her predicament because she didn't feel she had any options. She ended her communication with the thought that she would probably just go with what ever her doctor wanted because, "What choice do I have?"

She didn't *believe* she had options, so she didn't have any. Perception is reality.

While I refused to make her decisions for her, I felt I had given her enough information to open her options wide.

She could:

1. Take the science contrary to her doctor's conditions and request that he provide evidence to support his stance.
2. Request that the hospital base their policies on the safety of her and her baby instead of liability for themselves (remembering it is the doctors, along with their attorneys, that make policy).
3. If either or both refuse, find a doctor who did practice evidence based care.
4. If one could not be found in her area she could
 - a. Choose a homebirth midwife
 - b. Choose the nearest freestanding birthing center
 - c. Choose a hospital/doctor in a neighboring county
 - d. Even choose to go out of state to somewhere like The Farm in Tennessee where she could stay until the birth and then safely birth her baby.

Granted, not all of these are easy choices to make, but they have been made by other mothers. It is not only the right, but the responsibility, to ensure the options they are offered are safe and in the best interest of their baby. If not, they need to seek out new options. I'm sure there could be others I haven't thought of, but the point is she certainly not only 'had a choice', but several. The data I was able to provide on evidence-based care and safe birth did nothing to illuminate her options because it wasn't about *facts*...it was about *belief*.

Changing a belief system, especially one that's held collectively like our ideas about birth in the US, is a subject too complex for one article. My book *Mother's Intention: How Belief Shapes Birth: A Commonsense Guide to Safe, Comfortable, Guilt-free Birth in Five simple steps* (out in August 2003) spends a great deal of time on how to identify our faulty assumptions so that we may make better birthing decisions.

¹¹ Adapted from Dr. Phil, www.drphil.com

Suffice it to say, that even if someone doesn't instantly revise their beliefs on birth, really the only factors that should have any importance is if her choices are *based on fact*, if it is *in her best interest*, and if it *affects her experience positively* or negatively. Her concern need not be what is good for the hospital or doctor, but what is good for her and her baby. With those sole criteria, and "In the best interest of the child" firmly at the fore of her intent, her only responsibility is to look out for the child, and by extension, herself.

Same stuff, different day with two other calls in the last few months.

With one, the mother had talked about hiring a midwife for her second birth since her disappointing first birth.

She had done beautifully with her HypnoBirthing® the first time around. Her caregivers had tossed several red flags during the course of her pregnancy, giving her warning that they would *say what she wanted*, then *do what they wanted*. Still, for some reason she thought it would be different for her (a common belief among pregnant women—that somehow they will magically be able to change their caregiver when others have failed, by doing the same things others before them have done, yet expecting a different result).

Predictably, though she did well, at the very end they did what they promised they wouldn't...they coached her to 'purple push'...you know, the horrid, harmful purple faced pushing you see on those awful birthing shows. Amidst the yelling and counting, she couldn't stay focused on 'breathing the baby down', not to mention the fact that she was afraid for her baby...they had promised they would only do this if 'it was necessary for the sake of the baby'. The baby was never in peril. The mother (predictably) tore badly, which meant her early months of mothering were consumed with physical and emotional pain. Energy that should have gone to her child was wasted on trying to heal a relationship that struggled through the stress of a sexless existence.

In the years it took her to recuperate from that betrayal, she insisted she would have a homebirth with a midwife for the next baby. However, once she actually got pregnant, she went to an in-hospital birthing center that set right out with routine ultrasounds scheduled at 8, 12 and 20 weeks. Knowing the suspected risks of ultrasound, this made her uncomfortable, but she was staying with them because "*I have no choice. My insurance doesn't cover homebirth.*" Even *if* changing providers was impossible, though I believe nothing is impossible with enough determination, she had choices *within* that choice. She could refuse the routine technology and let it be known that if there was a legitimate medical indication that could be substantiated (they had given her a 'medical' reason for the intervention that with a little research was shown to be nonsense) she would surely cooperate for the sake of her baby.

No, her insurance doesn't cover homebirth. Because it didn't originate to help people get better care, it originated to help doctors get paid. Regardless, her co-pay for her hospital-birth-center birth was about the same as what a homebirth midwife charges. If this couple ends up with surgery, that co-pay will be much more, not to mention the ripple effect of what it will cost during her recovery, in subsequent births and the emotional toll.

She *believed* she had no choice, so she had no choice. Perception is reality. Another person might have seen the glass as half full instead of half empty. I see a multitude of choices here.

I was commissioned to do some birth art for someone recently. During the time I spent with the woman, she expressed anxiety over the fact that her doctor was starting to talk induction. She had read about the dangers of non-medically indicated induction and wanted to avoid it 'at all costs'.

She was a healthy woman, with a healthy baby, two weeks away from her estimated delivery date, which could be as much as four weeks from actually delivering. She enjoyed being pregnant and had a lovely support system through her husband and family. Her doctor's only reasoning behind mentioning induction was that she 'looked about ready'.

This mother's vehemence in her insistence that she wanted to avoid this intervention was impressive, but it didn't translate into action. When asked what she would be doing to avoid the induction she was so opposed to, she replied, "I guess I'll just have to do it. *I don't really have a choice.*"

Have you any idea how often these words pass over an expectant mother's lips?

You always have a choice. The question is *not* whether or not you have a choice, but are you willing to *make a choice*.

The minimum number of options is always:

- Do nothing and accept the consequences.
- Expend a small amount of effort by asking a few questions, but not following up. Again, accepting the consequences of non-action.
- Expend a fair amount of effort by asking the questions, continuing to ask until the words and actions of the respondent say the same thing.
- Expend a large amount of effort by asking the questions, continuing to ask, and if the words and actions of the respondent don't say the same thing in a reasonable amount of time, finding a new provider.
- Expend vast amounts of energy, asking, continuing to ask; seeking, continuing to seek until...until you have safe options from which to choose on your baby's behalf.

The questions then becomes, "How much effort is your baby worth?", "Where does your baby lie on the priority continuum?" and "Do your actions reflect that?"

Seek out support for your newfound freedom by hiring birth professionals who are well versed in informed consumerism and don't have anything invested in your choice. (Would it be logical to ask a car salesman about the merits of mass transit or a fast food

restaurant about the benefits of organic whole food? Does it make sense to ask an anesthesiologist about the risk of epidurals or a surgeon (obstetrics is a surgical specialty) about attaining a goal of natural birth?)

Parents have a multitude of choices to make from the time they discover they are pregnant. Each choice will either help them have a safer birth...or make their experience a little less safe. It's the responsibility of the parents to know learn about *all* of their options, verify which choices are based on fact, and ensure that their environment supports their efforts.

About the author:

Kim Wildner is the author of *Mother's Intention: How Belief Shapes Birth*. Sample chapters can be found at www.realsideofbirth.com and www.womanswisdom.info. She is married to her love of 20 years. They have one home-born daughter.