Evidence-based maternity care means practices that have been shown by the highest-quality, most current medical research to be most beneficial to mothers and babies (reducing incidences of injuries, complications and death), with care tailored to the individual. “Standard” or “routine” care—the care that the vast majority of women in most hospitals in the United States receive—is not evidence-based. That is, it is not based on the most current reliable scientific research.
Why don’t we practice evidence-based care?

The answer is not simple. There is no single place to point your finger.

Part of the problem is systemic.

It starts with medical and nursing education, where the focus is on what can go wrong during birth, not how to facilitate a normal, uncomplicated vaginal birth.

Here’s an example. Recently, a group of about 50 labor and delivery nurses from across the nation was asked how many had witnessed a natural, or physiologic, birth in their educational programs. About half raised their hands. But when natural birth was further defined as “undisturbed, without continuous electronic fetal monitoring, without I.V. fluids, with food or drink at will, freedom to move about and not confined to a bed,” the number of hands in the air dropped to one or two. This is standard education.

Part of the problem is public perception of birth.

For many people, “surviving” birth is the goal. They are not aware of the real benefits of normal (vaginal) birth for moms and babies, and that the effects of traumatic, out-of-control birth experiences—even when they result in a physically healthy baby—can be devastating. As one midwife and childbirth educator said, “The goal of emerging from birth with body and baby intact is a bit of a no-brainer, really. … [But also] it is completely possible to support a woman to birth a child so she feels mentally healthy afterwards, without compromising safety in any way.”

When we reduce birth to the extraction of a fetus from a womb, without regard to the physical,
emotional and mental implications of how it happens, it can be seriously detrimental to the postpartum experience. This includes how women recover from birth, parent their newborns, relate to their partners, and make decisions about future births. Artificial induction and c-sections can be life-saving interventions when necessary. The more women who have these procedures unnecessarily or routinely, however, the more these procedures appear normal, instead of the medical procedures they are, with real risks and consequences. More and more, women consent to have painful procedures and major surgery, with real health consequences, instead of being confident in their bodies’ abilities to naturally start labor and give birth to their baby.

Many women head for birth uninformed, unprepared and afraid. And most women do not get the benefit of practices, drawn from reliable research, that are proven to manage the pain and ease the process of labor, making it as safe and smooth as possible.

**Part of the problem is routines.**

An example of this is routine electronic fetal monitoring—the hospital practice of hooking up a laboring woman to a machine that monitors the baby during labor, while limiting the mother’s movement and ability to manage pain.

Research shows that routine monitoring increases the risk of cesarean delivery, the risk of forceps/vacuum assistance, and the risk of needing pain medication—all without making birth safer for the mother or baby. The lower-cost, scientifically proven better option of intermittent auscultation is only used about 3 percent of the time. It’s just one example of what one researcher calls “high-tech, high-cost, low evidence–based care.”