There’s a saying that birth is as safe as life gets. There are times when birth can become dangerous for the baby or, very rarely, for the mother. This is when hospital-based maternity care really shines, and we're able to save mothers and babies who a hundred years ago might have died. Thank goodness that there are skilled surgeons who can come to the rescue when truly necessary.

There's also another saying: When you're holding hammer, everything looks like a nail. Likewise, for hospital-based birth attendants, it is easy to become accustomed to treating every birth as a disaster waiting to happen. Many obstetricians have lost touch with the possibility of normal birth, so much so that even labor that includes a pitocin induction with an epidural, a fetal scalp electrode and a vacuum extraction is called a “natural” birth. Some hospital staff seem offended by the idea of minimizing interventions, as if preferring not to have a needle the size of a house nail inserted near your spine is the same as declining to have a second piece of Aunt Sally’s fruitcake. Sadly, some of today's younger doctors may never even have seen a truly physiological labor and birth—a birth completely without medical intervention.
This is how the saving grace of the hospital can become the scourging disgrace of maternity care. In their rush to prevent problems that aren’t happening, hospital personnel may aggressively push procedures and drugs that can actually cause problems. Pitocin can cause uterine contractions so strong that they stress the baby and cause fetal distress. IV narcotic drugs can affect an infant so strongly that he might not breathe at birth—a second drug is used to counteract the narcotics to help these drugged babies breathe. There is considerable debate as to how epidurals affect the progress of labor, but they certainly diminish a woman’s ability to get into a squat, which opens the pelvic plane by 20 to 30 percent; anyone can understand that this could affect the possibility of the baby’s fitting through the pelvis. Epidurals can lower the mother’s blood pressure so that the baby isn’t getting enough oxygen through the placenta. This can cause fetal distress and the need for an emergency caesarian section to rescue the baby.

In addition to the specific dangers of individual obstetric intervention, hospital births suffer the effects of any form of institutionalized care. Perhaps the best-known risk of hospital birth is hospital-acquired infections. The people most susceptible to such infections are those with compromised immune systems, such as newborns. In particular, a baby is born with a sterile skin and gut that are supposed to be colonized by direct contact with the mother’s skin flora. If antibiotic-resistant hospital germs colonize the baby’s skin and gut instead, the baby will be at high risk of becoming very sick from infections that are very difficult to treat. The overall infection rate for babies born in the hospital is four times that of babies born at home, and these infections are more likely to be antibiotic-resistant.

Ninety thousand people die every year from hospital-acquired infections. That’s more than from all accidental deaths put together: 70,000 people die from motor vehicle crashes, fires, burns, falls, drownings and poisonings combined. An additional 98,000 people die each year from general medical error.
Another obvious risk of institutionalized care arises from the piecemeal nature of the care. Because there are so many different kinds of personnel performing so many different procedures, there is a lot of potential for miscommunication about critical matters. In an astoundingly progressive admission of institutional shortcomings, Beth Israel Hospital in Boston published a paper about a tragic miscommunication that resulted in a baby’s death. To their great credit, instead of covering up this horrible mistake, Beth Israel used it as a wake-up call to revise their protocols, in an attempt to reduce miscommunication and increase safety. Unfortunately, other hospitals are slow to adopt their reforms.

One of the most dangerous aspects of hospital care is that those providing most of the direct care (i.e. nurses) are hierarchically subservient to those managing the care from a distance (i.e. doctors). This power structure can prevent knowledgeable nurses from mitigating potentially dangerous actions of a misunderstanding doctor.

Many people feel that a hospital must be the safest place to give birth because of all the equipment it has. But equipment is only as good as the people using it. In many hospitals, there are not enough registered nurses to cover all the patients, so they use medical technicians, who are trained to perform procedures but not necessarily trained to interpret fetal heart tracings. Most labors start at night, especially for women birthing second or subsequent babies. This is the time when the senior staff are off-duty, because their seniority allows them to opt for the more desirable daytime shifts. A recent study confirmed that birth outcomes are worse during the night. Even the most sophisticated equipment is useless in the wrong hands.

(For the record, many homebirth midwives now carry equipment that is as sophisticated as that in most hospital birth rooms. This includes continuous electronic fetal monitors and equipment for performing neonatal resuscitation if necessary.)

Institutionalized care also suffers from the economic pressures of running an efficient organization, regardless of how this might interfere with the normal process of labor and birth. Sometimes doctors recommend pitocin without true medical necessity, simply to hasten the birth. This may be due to a need to free up a birth room to make room for other patients, or because the doctor has other responsibilities elsewhere. Stimulating labor artificially overrides a baby’s ability to space out the contractions if
the labor is too stressful. This increases the risk of fetal distress.

Hospital staff have a strong bias towards confining laboring women to the bed and requiring them to push in a reclining position. This often puts a baby’s weight on the placenta or umbilical cord, possibly restricting the baby’s supply of oxygenated blood from the placenta. In contrast, upright positions put the baby’s weight downward, toward the open cervix and away from the placenta and umbilical cord, reducing or eliminating fetal distress caused by cord compression.

A rush to clamp and cut the umbilical cord within seconds after birth is one of the most dangerous hospital practices. This premature severance of the umbilical cord cuts the flow of oxygenated blood to the baby before the baby has established the lungs as the source of oxygen. Premature cord clamping also deprives the baby of the blood that would naturally fill the pulmonary vasculature as it expands in the minutes immediately after the birth. This practice has been documented to increase the risks of neonatal hypoxia, hypovolemia and anemia, thus increasing the need for blood transfusions.

There is some very new research showing that placental tissue itself may be a rich source of pluripotent stem cells (cells which can give rise to any cell type) in addition to the blood stem cells in blood drawn from the umbilical cord. We do not yet know whether premature cutting of the umbilical cord halts the migration of pluripotent stem cells from the placental tissue into the baby’s body to repair damage from even minor birth trauma.

Separation Anxiety

Perhaps the most egregious and unnecessary interference with the normal birth sequence is the separation of mother and baby immediately after birth. Even a ten-minute separation is too long during this critical first hour after birth—it prevents the natural nipple stimulation that increases the mother’s oxytocin, which will contract the uterus and prevent a postpartum hemorrhage. Instead of baby-provided nipple stimulation, hospitals are now routinely using synthetic oxytocin by IV or injection after the birth to control bleeding.

Similarly, early cuddling of mother and baby stimulates oxytocin production in the newborn, thus
raising the baby’s body temperature to help with the adaptation to the extrauterine environment. A mother’s body is a newborn’s best warmer.

Because different personnel are involved in providing piecemeal care for mothers and babies, providers do not always see how their actions in one area may cause problems in another. For example, because obstetricians are not involved in breastfeeding issues, they may not realize that cutting an episiotomy hampers a woman’s ability to sit comfortably in order to nurse her baby. Likewise, pediatricians may not realize that separating the mother and baby right after the birth in order to do a routine newborn exam also interferes with breastfeeding. Nursery nurses often do not seem to appreciate the importance of minimizing the separation of mother and baby, and thus also unwittingly interfere with breastfeeding. They tend to ignore the World Health Organization’s recommendations to delay initial bathing of the baby until at least six hours after the birth, even though bathing can cause a baby’s temperature to drop so dangerously low that they do not return him to his mother for an hour or more.

I emphasize the hazards to the breastfeeding relationship because breastfeeding is so vital to a newborn’s well-being, reducing infant mortality by 20 percent. This is a huge health benefit, and hospitals should be taking the lead in tailoring their routines to support breastfeeding. But because the functions of caring for mother and baby are separated into the roles of maternity nurses (who care for the mothers) and nursery nurses (who care for the babies), sometimes the mother and baby are also physically separated. Most of the time, there are no lactation consultants in the hospital—they are often only available during weekday business hours. But babies need to be fed around the clock, and if a lactation consultant isn’t available to help a struggling mother/baby pair, it might become necessary to feed the baby artificial breastmilk with a bottle, which further interferes with successful breastfeeding.

Because the entire model of hospital birth is based on birth as a medical procedure, hospital staff seem to miss the fact that they are interfering in a delicate time in a new baby’s life. Perinatal psychologists describe the first hour after birth as the “critical period,” during which the baby will learn how to learn and whether or not it is safe to relax and to trust the outer world. This has tremendous implications for mental health and stressrelated disorders.

A Natural Process
There was a time when cesareans were acknowledged to be a risky surgery reserved to save the life of the mother or baby. Now even cesarean surgery has become almost routine. Some obstetricians and hospital administrators are advocating for a 100 percent cesarean rate as a solution to liability and scheduling problems that are inherent in providing maternity care. Unfortunately, cesarean surgeries increase risks for the mother and child. They also increase the risk for subsequent pregnancies, with higher rates of placenta previa and placenta accreta, and introduce a small but non-zero risk that a pre-labor uterine rupture could result in the baby’s or even the mother’s death.

When someone needs to be in the hospital receiving medical treatment for a lifethreatening condition, the risk-benefit trade-off comes in heavily on the side of benefit. But for women who are hoping to have a drug-free birth, it makes no sense to expose themselves and their baby to the various infection risks associated with simply being in the hospital.

Most people know that it is unwise to take a newborn baby out and about in public because of the risk of exposing the baby even to ordinary germs. It is an even worse idea to expose the baby to the antibiotic-resistant strains of germs commonly found in hospitals.

When a woman planning a homebirth needs medical care and care is transferred to a hospital-based provider, the phrase “failed homebirth” is often written in her chart, even if she goes on to have an outcome that is better than if she had started out in the hospital. I would like to propose the concept of a “failed hospital birth” as any birth where hospital procedures specifically cause more problems than they solve. When you consider hospital infection rates, surgical complications and the damage to the breastfeeding relationship caused by routine separation of mother and baby, we might find that close to 95 percent of planned hospital births are failed hospital births. They failed to support the mother in an empowering birth experience to better prepare her for motherhood, and they failed to satisfy the baby’s overwhelming need and desire to enter and adapt to the outside world as nature intended.

Our society has an obligation to improve maternity care services as much as possible. Consider that the countries with the safest maternity care rely on midwives as the guardians of normal birth, reserving risky medical procedures for cases of true need. “In the five European countries with the lowest infant mortality rates, midwives preside at more than 70 percent of all births,” reported Caroline Hall Otis for the Utne Reader. “More than half of all Dutch babies are born at home with midwives in attendance, and Holland’s maternal and infant mortality rates are far lower than in the United States...”
A Return To Midwives

The United States needs to return to a model of midwives as the default maternity care providers, reserving the surgical specialists for the highest-risk patients. We need to educate pregnant women so that they understand that the choices they make about drugs during labor affect their baby, just like the choices they make about drugs during pregnancy. We need to offer women realistic pain relief alternatives to dangerous pharmaceuticals; warm water immersion during labor provides risk-free pain relief that many women find as satisfactory as an epidural. (Mothers who are uncomfortable with the idea of water birth can easily leave the tub to give birth “on land,” while still deriving the tremendous comfort and safety benefits of laboring in water.) Hospitals need to develop new routines that protect mother-baby bonding and the breastfeeding relationship as if they are a matter of life and death, because they are.

Obstetricians would do well to practice according to the wisdom contained in the phrase, “If it ain’t broke, don’t fix it.” This means supporting healthy women with normal pregnancies in birthing at home if they choose, and encouraging women planning hospital births to work with them to minimize interventions that turn normal births into risky medical procedures.

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Dangers of Hospital Births: Why Birthing in a Hospital Can Cause More Problems than it Solves

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