Chapter One ~ A Time Traveler

I am a time and place traveler who watched the 20th century history of childbirth unfold, decade by decade. I experienced it first-hand as a labor and delivery room nurse, childbearing woman and a professional midwife. As a curious person with lots of questions about what I saw, I studied everything that came into my hands on the history of maternity care, normal childbirth, and the practice of obstetrics through the ages. At 64 years of age, I have now dedicated the last stage of my professional life to telling what I describe as "**the last and most important *untold* story of the 20th century**". The best-kept secret in modern times is *how and why normal childbirth in a healthy population became the property of a surgical specialty and what the current costs and consequences of that are*.

The best place for me to start this story is where it started for me – with the life-changing experiences I had as an 18 year-old nursing student in a racially segregated hospital in the South and later as graduate nurse working in the labor & delivery room of that same segregated hospital. I characterize this as the 'Dark Ages of the Deep South'. Due to a two-tiered (unequal) system of medical apartheid, I got to closely observe and directly participate in two entirely different systems, side by side, in the same hospital, at the same time, with the same staff and the same type of patients but totally different management style and outcomes, different as day and night.

It was a naturally-occurring, one of a kind scientific study of two contrasting types of childbirth management. One was a profoundly interventionist model characterized as "knock'em out, drag'em out" obstetrics. This is style of obstetrical management introduced by Doctors DeLee and Williams in 1910 and was used on our white maternity patients, with only minor modifications, for the next fifty years. For our black mothers, the counterpoint to intense obstetrical intervention was a lazier-fair system, the classic physiological management provided by family-practice physicians and midwives in other parts of the world. In 1961, it all depended on whether the mother was black or white.

Childbirth in Black and White

In our segregated southern hospital, Caucasian mothers were sent to the all-white labor ward on Five-North. On admission they were isolated from their family, asked to take everything off (we meant *everything*!) and get in a hospital gown. Then the mother's clothes, eyeglasses, weddings rings and other jewelry, any dentures, braces, crutches (or artificial limbs) were placed in a brown paper bag and given to her husband in the waiting room. Fathers were not allowed in the labor and delivery area, so he was encouraged to go home, as he would not be able to see his wife until well after the baby was born. This was often 24 to 36 hours later.

Then newly admitted white patients were subjected to the traditional obstetrical 'prep'. Because poor women in the early 1900s sometimes had public lice, hospital policy in the 1960s still required our white labor patients to have their public hair lathered up and shaved off. Because physicians in the early 1900s believed that infection following childbirth was sometimes the result of 'autogenesis' – that is, bacteria in the mother's own vagina or intestines -- our labor patients were still being given a large soapsuds enema on admission. This was sometimes repeated every 12 hours if they weren't in good labor. Once the admission rituals were concluded, laboring women were routinely medicated with 3 grams of barbiturates -- a double dose of sleeping pills --

and put to bed.

As labor progressed they were injected every 2-3 hours with a narcotic mixture known as "twilight sleep" – large and frequently repeated doses of morphine or Demerol, a tranquilizer drug and scopolamine. Scopolamine is a potent hallucinogenic drug that causes short-term memory loss and permanent amnesia of events occurring under its influence. Under these powerful drugs some women became temporarily psychotic and fought with the staff, sometimes even biting the nurse. If left unattended, medicated patients often fell out of bed and chipped their teeth or broke an arm. To keep drugged women from getting hurt, the hospital required a nurse to stay right at the bedside through out the entire labor.

Whenever the nurses were too busy to be able to stay with each patient full time, our white mothers were put in four-point restraints, with arms and legs attached to the rails at the four corners of their bed. These were the same heavy leather restraints used in the locked psychiatric wards of the hospital. This forced women to labor while lying flat on their back, a position that reduces blood flow to the uterus and placenta, making labor extremely painful and often causing fetal distress. Because labor was more painful when women were on lying on their back, the obstetricians in our area believed that labor was more effective when women were on their back, so they saw the use of leather restraints as an effective method for advancing the labor.

When the time came to give birth, mothers were moved by stretcher to an OR-type delivery room, put in stirrups, their pubic region scrubbed again and painted with Mercurochrome and then they were put to sleep with general anesthesia. In the late 1950s and early 1960s, the third leading cause of childbirth-related maternal death was complications from obstetrical anesthesia. After the mother was unconscious, a "generous" (!) episiotomy was done, and the delivery room nurse was instructed to provide "fundal pressure" (pushing hard on the top of the uterus to press the baby down farther in the birth canal) as the baby was extracted by the obstetrician using 'low' forceps. This was followed by the manual removal of the placenta and suturing of the episiotomy wound.

For white babies that arrived under the standard obstetrical management, respiratory depression was the inevitable result of the narcotic drugs, anesthesia, anti-gravitational positions for pushing and the use of fundal pressure and forceps. The well-known effect of drugs and anesthesia was to obliterate the newborn's normal gag reflex (all general anesthesia has this effect). Since the early 1900s, it has been the standard of care to vigorously suction the newborn's nose and throat with a bulb syringe and repeated anytime there was a concern about the baby's ability to breathe or any signs of choking. One of my jobs as a nurse in the all-white Five North delivery room was to resuscitate the many depressed babies who did not spontaneously breath at birth. As a consequence of general anesthesia and/ or the use of obstetrical instruments, a significant number were never able to breathe on their own. The high mortality rate of the era was primarily due to these iatrogenic factors.

For the obstetrician, routine care for white patients usually ended with the infamous "husband stitch". Double entente comments often accompanied this, as the doctor added a few extra perineal sutures to make sure the mother's vagina was tight as a virgin's again for her husband. Doctors explained that some of their new fathers complained that: "*Ever since the baby was born, having sex with my wife is like walking into a warm room"*. Our doctors apparently felt

responsible for preventing this type of marital dissatisfaction.

After finishing his handiwork and removing his surgical garb, the obstetrician walked over to the waiting room and announced to the family that: “It’s a boy!” or “It’s a girl”. He would congratulate the father with a handshake and bask briefly in the family’s appreciation of his skill in safely delivering their baby, then send the relatives over to the nursery window for their first look at the newest arrival.

For the new mother, obstetrical management in the all white unit ended by being wheeled, still unconscious from the effects of anesthesia, to the recovery room. There she would lie on a stretcher for a couple more hours, retching and vomiting her way back to a dim consciousness before she finally asked “What did I have?” White mothers were always the least important person in this process and the very last to know about their own birth.

The Other Half of the Story

As a student nurse, my head was still swimming from all this when I rotated off Five North to One South, the all-black ward. Oddly enough, the maternity care for black mothers was remarkably simple, straightforward, non-interventive, and in my uninitiated 18 year-old opinion, infinitely more humane. It met the mother’s psychological needs and made right use of gravity. Biologically speaking, it was both safe and effective. As judged by the number of newborns who did not need resuscitation at birth, it was vastly more successful than the medicalized version visited on their Caucasian counterparts upstairs on Five North. Frankly, all this was a big relief to me. It troubled me to be used an agent for a process that appeared to harm mothers and babies.

One South was a segregated ward in the basement of our hospital. The all-black ward was one of the oldest and most crowded wings in the hospital complex, shoe-horned in between the huge kitchen, industrial-sized boiler room and hospital laundry. One South had no labor ward or labor room nurse to care for black mothers, so black labor patients were just admitted to their postpartum beds in an old-fashioned four-bed ward. There were no admission rituals, no pills, no rules that said that black women had to labor in bed on their back.

In contrast to the restrictive policies and tight control in the all-white labor ward on Five North, the labors of our black mothers were not accelerated with Pitocin or any other drugs. Nor were they given ‘twilight sleep’ drugs for pain because there were only two staff nurses. They were already responsible for 40-plus other patients and had no time to labor-sit with drugged and combative women having hallucinations and trying to climb or fall out of bed. But in our segregated society, what black women in labor wanted (or didn’t want) just didn’t count. However, there were many unintended advantages to this system of purposeful neglect.

Left to fend for themselves, black labor patients moved around the big room, cheered on and cheered up by the older and more experienced women in the four-bed ward. This provided a useful source of encouragement and tips on how to cope with labor pain. Because they were undrugged and unencumbered, black mothers in labor were able to walk about freely, change positions at will or take themselves to the bathroom and sit on the toilet as the baby descended in the pelvis and they began to feel pushy. In particular, black mothers avoided lying down in bed, preferring to stand and hold on to the foot of the bed as they swayed or squatted during contractions. As a naive

student nurse, I remember asking one young black mom why she didn't just lie down in the bed so she would "be more comfortable". She looked at me like I was a total idiot and in an irritated voice said: " …'cause it hurts too bad when you lay down!"

By an accident of race, these childbearing women were the beneficiaries of racial policies based in prejudice which co-incidentally shielded them from narcotics and artificial hormones drugs to speed up labor or being forced to push in anti-gravitational positions. The labors of our black mothers were undisturbed and with rare exception, the physiological process unfolded as Nature intended.

Eventually one of our black maternity patients would start to make deep-throated guttural noises -- the unmistakable sounds of pushing. One of the floor nurses would grab a stretcher and help the mother lay down on it. Then we raced the stork through the hall to the elevator, hoping to make it to the 5th floor delivery room before the baby made its entrance. It was my frequent pleasure, as an impressionable student nurse, to 'catch' their precipitously born babies in the elevators that traversed the vertical and political distance between One South and Five North.

These normal births were managed physiologically by the nurses, which is to say, the mother gave birth spontaneously, pushing her baby out under her own powers. And wonder of wonder, these babies immediately breathed on their own, since their mothers had not been given narcotics or anesthesia and no artificial, forcible or mechanical means were used to accelerate the labor or pull the baby out. There was no painful episiotomy, no bleeding from a perineal incision, no forceps, no fundal pressure, no bulb syringe thrust repeatedly down the baby's throat, no manual removal of the placenta. These lucky babies were enthusiastically embraced by their undrugged and fully conscious new mothers, who beamed proudly and proclaimed: "Look what I did!"

By today's legal standards these black mothers were actually receiving "substandard" care. Racial prejudice and discrimination of the era had institutionalized what would be considered legally negligent treatment. Yet, they clearly were getting the better end of the deal. The nurses just talked these black mothers through the last couple of pushes and their babies just slipped out, with little fuss.

Had anyone in our hospital or our town or any researcher at the CDC been paying attention to this impromptu study of two opposing styles of birth management, the winner would clearly been the black moms on One South. They enjoyed the safer, physiologically managed labors and normal spontaneous births, while being protected from the routine indignities and painful interventions that were the norm five floors above. Our black labor patients were not subjected to the labor-retarding effects of social isolation or immobilized on their backs with four-point psychiatric restraints. They did not have their memory erased by scopolamine or their labor slowed down by narcotics, no routine use of forceps damaged to the mother's pelvic floor or her baby's cranium. The new mother was not debilitated by the slowly healing episiotomy that made it hard to sit and difficult to care for a new baby. Their babies were not exposed to intrauterine narcotics and the resulting fetal distress, nor did they need to be resuscitated. This no doubt contributed to increased IQ points and, according to three Scandinavian studies, a reduced the incidence of drug addiction as young adults. It was clear to me that Mother Nature knew what she was doing.

A Practical Application of our Black-White Study –an "N" of one

When expecting my first baby, I took my lesson in childbirth out of that same book. In an attempt to avoid the detrimental effects of these interventions, I asked my obstetrician if I could have the same kind of care that our black mothers received. He smiled and kindly suggested that I just stay out of the hospital until the baby was ready to be born because "that's what hospitals are for -- drugs and anesthesia".

As a good and faithful nurse I did as I was instructed to do by my doctor. I labored at home as long as possible, hoping against hope to have a nice nurse-managed birth on a stretcher in that same elevator on the way up to the Five North delivery room. As luck would have it, I misjudged by just a few miles. While my husband drove the family car, I gave birth in the back seat of our Renault to a lovely baby girl, just five blocks before we turned into the hospital driveway. It was one of the most surreal moments in my life – to be the first person after God to welcome and hold my brand new daughter. That was the second milestone along the road to my eventual career in midwifery.

My L&D Time Warp – 1910 to 1976: Historically speaking, the policies and the process for providing obstetrical care to the white population of our hospital in the 1960s were *pristinely unchanged since 1910,* except for replacing the chipped white paint on the OR-style delivery table for shinny new chrome and substituting safer cyclopropane anesthesia for the much more dangerous chloroform and drip-ether. On my last day of work in the L&D unit of that hospital in August of 1976, the obstetrical protocols still included routinely confining the mother to bed, medicating her with narcotics and scopolamine during labor and giving general anesthesia for delivery. Normal birth was still conducted as a surgical procedure that included episiotomy, forceps, manual removal of the placenta and sutures. It still ended with the mandatory separation of mother and baby and the unconscious mother was still the last to know 'what she had'.

As a L&D nurse, I worked as hard as I could for years to rectify the tension between the two opposing models of maternity care used by every hospital in our part of the state. But I was utterly unable to make the 1910 version of obstetrics move even a tiny millimeter towards the physiological model that served our black moms so well. It finally became obvious that normal childbirth was permanently trapped on the wrong side of history, at least in Orlando, Florida. I threw in the towel and asked to be transferred to the ER, where I worked as emergency room nurse for the next several years. I too was traumatized by being the agent of the 'new' obstetrics to ever again be employed in a system that required me to do things I knew were harmful, humiliating and painful. Eventually I joined a domestic Peace Corps project was doing community development work and moved to the project in North Carolina.

Relieved of these onerous duties, I was able to study the problem without so much emotional angst and to get a better perspective on the right use of obstetrical interventions and the best form of care for healthy women. What I discovered was heartening, as it provided logical reasons for why and how the 'new' obstetrics came to be at odds with the fundamental purpose of maternity care, which is to make normal childbirth safer and more satisfactory for healthy mothers and their unborn/newborn babies. My study brought me insight, a rational plan to address the immediate problems and a set of principles for restoring balance and rehabilitating our national maternity care policies. Healthy women should never be forced to choose between an obstetrician and a midwife

or between a hospital and a planned home birth in order to get physiologically-managed maternity care.

One of the most simple and central issues is the current use of a surgical billing code for physiological childbirth. Normal birth needs its own specific billing code. A physiological code would once again acknowledge that childbirth is a continuum. Continuity of care by the primary birth attendant during active labor, the birth and the first hour or two of the new baby's life is a *biological imperative for safe childbirth.* Fair compensation for birth attendants, via a physiologic billing code, is *an economic imperative* for birth attendants and institutions and the lynch pin to making the system work for everyone.