True North

When I was twenty-six years old, I decided to become pregnant. I embarked on that journey with great conviction and a detailed list of pitfalls to avoid. I had learned well how not to be a mother, having myself been mothered by a woman with all the warmth of a feral cat. I had questioned long and hard whether I wanted to take on the task, but had decided that motherhood was a challenge that I would conquer, an example of how unlike my own mother I was. I would be a mother, a good one. I had no questions, no concerns. Chin first, I headed toward my future.

Looking back I realize that my moral compass was somewhat skewed. While the needle of a compass points north, helping its user navigate from a reliable orientation, my personal compass was pointed firmly and directly in opposition to my mother. Anything she had done was wrong, and I would do the opposite. When my mother had been pregnant with my little sister, she had hired a midwife. "Birth as nature intended it," I remember her exclaiming between long pulls on her Pall Mall cigarettes, an ashtray balanced on her pregnant belly. Knowing my mother, I was sure that this was another self-centered decision designed to feed her sense of superiority. I would give birth in the hospital, safely, the way women are supposed to.

Sometime during my second trimester, uncertainty began to creep in. I worked in a physical job, hefting boxes and walking in circuits around a large mailing facility, and found that I couldn't do all the things I had done before without discomfort. After years of being an over-achieving, capable and in-charge woman, another person was suddenly at the controls of my own body. Still, I moved boldly forward, not admitting that I was concerned about my loss of control. Then I was in pain. Halfway through my pregnancy, it hurt to walk, to bend, to cough, and I became convinced that something was wrong. Nobody told me that pregnancy would hurt, and I

knew I could not survive another four months. With weakening resolve, I began to question how much I really knew about pregnancy.

When I asked my obstetrician, Dr. Perry, he laughed at me. "Your uterus is descending into your vagina," he said. Several questions filled my mind. "Wait, what? It's not time to have the baby. Am I going into labor already? Will my uterus go back up? But he's laughing so this must be normal, and if I ask more questions I will look stupid." Instead of asking, I said only, "Oh, okay." Dr. Perry said that he would see me in a month. Now I was in pain and I felt foolish. The next month Dr. Perry wasn't available and I saw his colleague. The next visit yet another doctor rushed me through the office. Feeling foolish and lost, I decided I needed to take a childbirth class.

I began the childbirth education class dubiously. What did I need to learn about childbirth? I would go to the hospital, get an epidural, and before I knew it the baby would be out. But the birth educator, Heidi, could tell me how to survive until then, so I would give it a try. I went with my cousin, Eliza, who was going to be at the birth and let me order her around, though I described the job to her as "loving labor support." This would be fun, if not valuable.

Heidi led the class of about ten pregnant couples in massage and breathing techniques. Then she taught us different possible birthing positions. She reviewed all the amazing and extreme things that were happening to our pregnant bodies, complete with pictures. When Heidi showed the video of the live birth the men laughed uncomfortably. "This is a waste of my time," I thought. "I am going to have an epidural, snuggle up in bed, and let the baby come out as he pleases."

Then Heidi asked us what we knew about epidurals. I raised my hand. "They are God's gift to women," I said. She smiled knowingly. Suddenly, I got the chafing sensation I sometimes

feel when someone near me knows more than I do, and I knew that Heidi was going to challenge what I thought I knew.

That night in Heidi's class I heard the term, "cascade of interventions." Heidi explained that the cascade of interventions happens when the natural progression of labor is tampered with in some way. The most common pain management medication used is the epidural, and the most prevalent side effect of epidurals is that they slow down labor (Harper, 1994). If labor stalls, the hospital staff needs to get it back in gear with Pitocin, a synthetic form of Oxytocin, the hormone that causes contractions. Because the mother is on so many medications, the staff straps her with a continuous electronic fetal heart monitor to ensure that the baby's heart rate is stable and there are no signs of fetal distress.

The Pitocin stimulates unnaturally long and intense contractions, and the epidural stops the mother from releasing endorphins to share with the baby. As a result of these two interacting interventions, the baby is squeezed and crushed but gets none of the pain relief it is supposed to receive. Before long, the fetal heart monitor registers signs of distress. In order to minimize further stress and possible injury to the baby, the doctor usually decides that an emergency Cesarean section is needed (Childbirth Connection, 2011). During the Cesarean procedure, the mother and baby are separated at birth, and she cannot hold the baby for an extended time while she recovers from major abdominal surgery. Nursing is immediately impacted as the mother is left with a deficiency of Oxytocin, the valuable hormone that continues to function after birth to enable the mother to release milk (Epstein, 2007).

According to Dr. Marsden Wagner, Cesarean sections come with a significantly higher risk of death for both mother and child (Wagner, 2000). Partially because of our high Cesarean rate, America ranks thirty-second of all industrialized nations for positive outcomes for mothers

and babies (BBC News, 2009), meaning that thirty-one other nations have better maternity models than we do. The primary difference between our model and theirs is that, in most other nations, healthy low-risk births routinely occur outside of the hospital and are attended by midwives (Rivett, 2010). As a result, birth interventions are minimalized, and the health of mothers and babies is not put at such high risk. Confronted with this information, I began to wonder if I was making the right decisions for my health and for the health of my son. Rebellion against my mother had made me feel secure but, for the first time, I began to see how it could also be self-destructive. I could no longer continue to navigate moral complexities of life by comparing myself to my mother. I would have to find direction from within myself.

When I accepted this knowledge, my world opened up. I was able to recognize truths that challenged my worldview, and suddenly I had options that did not exist before. By then, I was well into my final trimester, but I finally had informed questions about how I would give birth. I went to see my doctor. Again, a stranger met me because my regular doctor was unavailable. When I asked when I would see Dr. Perry again, the answer was vague. Then I asked if my doctor would be at my son's birth. I was told, "Probably not." Apparently the staff doctors worked on rotation, and I would have a one-in-ten chance that Dr. Perry would be on call during my labor. Next I asked if my baby and I would be separated at any time in the hospital because I did not want my son taken from me for any tests or procedures. The answer again, was vague. Finally, I asked who I should talk to about my birth plan. To that I was told, "The hospital has a plan. You are in good hands." The staff doctor's tone implied that I should stop asking silly questions.

For the final birthing class, we met for a tour of the labor and delivery ward at Tallahassee Memorial Hospital. Our class of ten women, along with our birthing partners, piled

into a cramped vacant labor room, and Heidi began to show us how the different machines in the room worked. First, she presented the IV that would be attached to us. Then, she described how the monitors would be hooked up, but all I could see was how they would effectively tie me down. When Heidi showed the fetal heart monitor that would be wrapped around our midsections, I began to wonder whether I would be able to move. She let me hold the probe that the doctors might place under my son's scalp to monitor his brain activity, a slender needle to pierce his perfect skin before he was even fully born. She demonstrated the heat lamp he would lie under immediately after birth, as if my own body heat would not be adequate. When she showed us the nursery, I showed myself the door. I could not give birth in that place.

I began to question some aspects of myself. I knew that I was a control freak, and I knew that I tended to rush into, or out of, situations without first weighing my options. I also knew how hard it was for someone to convince me that I was wrong. Above all, I knew I was not my mother. Now I confronted everything I did not know. Was I strong enough to have my baby without medication? Did I really know what I was doing? Did I have any right to have my baby outside of the hospital? Was I doing this for the right reasons?

I uneasily began to take the path my mother had traversed years before, but I would not follow blindly. For the first time, I would have to decide my course independent of my mother's example. I would have to admit that she had done some things right, but that choosing a similar path did not make me like her. Now to make good choices for my son, I would need to consult my own morality and knowledge.

I chose The Birth Cottage, the same place where my younger sister had been born. Sensing the ghost of my mother in every room, I felt small, like the mighty who had fallen. To admit that my mother had done one thing right felt dangerous. Yet, I was in a strangely familiar

place with strangely familiar people, a small home that sat several blocks west of the hospital. And then it happened. A midwife sat down for an hour and actually talked with me. She wanted to talk about my upcoming birth. She answered all of my questions. She asked me things I had not considered. Then, she assured me that either she or her daughter would attend the birth of my son. I met her daughter, and I was suddenly home. All feelings of anxiety and uncertainty faded. Knowing that I was surrounded by knowledge that far outstripped my own, I settled in. These women would teach me more than I had ever wondered.

Three weeks later, I gave birth to my son. It was a painful, magical, happy day. I walked, and moved, laughed and cried, ordering everyone around the whole time. Question one had been answered: I was indeed strong enough to give birth to a healthy baby without any medication. With faith in my intuition, I had changed the story of my son's birth, and claimed my right of passage, but I still had more questions than answers. I didn't really understand why the hospital care system had made me so uneasy, so I decided to find out.

I have never been a person who becomes involved in social issues. When my mother decided that feminism was the next vogue thing, I rolled my eyes. When my grandmother pronounced her stance on the rights of women to have abortions, I went outside. When my father described the needs of convicts released from prison, I buried myself in a novel. I didn't have enough information to support a passionate position, or enough concern to learn more. Suddenly, however, I was passionate. I had given birth outside of the medical establishment, and I had enjoyed my labor. I knew there was something very right about midwifery care for healthy pregnancies and births, and I felt so strongly that I began researching the facts. The more I learned, the more I understood that I had chosen the safest birth for my son. Becoming more educated about maternity care in America, I began to wonder why midwifery care only accounts

for eight percent of American births (Jordan, 1993). I became concerned about how birth is being handled in our nation and began to wonder how I could work to change the status quo.

As it stands, the statistics of American birth indicate that labor and delivery is becoming more dangerous. Today in America, a woman is more likely to die in childbirth than her mother was, and between 1987 and 2006 the American maternal death rate more than doubled (Piche, 2010). Even though eighty-five percent of pregnancies in America are medically low-risk, nearly every pregnancy that takes place in American hospitals involves at least one labor intervention (Harper, 1994). This starts the cascade of interventions. The result is that approximately one in three American women give birth by Cesarean section (Barber, Lundsberg, Belanger, Pettker, Funai, Illuzi, 2011).

Perinatal problems after Cesarean sections stem from the short circuit that surgery creates in the mother's physiology. When mothers circumvent natural labor either with Pitocin or Cesarean sections, they do not release natural Oxytocin. While Oxytocin causes contractions, it serves other crucial functions as well, including stimulating a protective instinct and feelings of love in the mother. While mothers often believe that such feelings come naturally, they may not realize that these feelings result from a natural biological process. When mothers do not release adequate Oxytocin, they experience a subsequent emotional detachment from their babies, sometimes followed by guilt and depression (Epstein, 2007). Compounding all of this, the exhaustion and pain that mothers feel after Cesareans is more intense than for mothers who deliver vaginally (Harper, 1994). Mothers who have given birth naturally are infused with Oxytocin and endorphins (Childbirth Connection, 2011). As a result, they experience acute euphoria and a rush of intense love and well-being when they meet their new baby.

As I have learned more about the physiology of birth and bonding, I find it difficult to believe that this information is not common knowledge. I visualize my own stereotype of the brave American woman in charge of her life, knowing her rights and defending them adamantly. However, the majority of women in America do not know the implications of the choices they make in their maternity care. They don't know about the cascade of interventions. They don't know the risks associated with epidurals, and they don't know that the need for Cesarean sections in low-risk natural childbirths is relatively rare (Harper, 1994). They are afraid to birth outside of the hospital because the use of Cesareans has become so common that a culture of fear has been created around childbirth. Women are afraid they will need emergency care, and they believe that birth with midwives will not provide the safety net they may need.

Fear has infected nearly every facet of childbirth in our culture. American women are afraid they cannot handle the pain, but the majority of doctors do not educate women about alternative pain relief. In fact, in medical school most obstetricians never witness a natural labor (Rivett, 2010). Many doctors don't tell their patients that outside of medication, submersion in warm water is the most effective pain relief during labor because many of them do not know that themselves. Because these doctors have been educated solely on medical birth techniques, they encourage their patients to use epidurals and many even limit their patients' access to alternative pain management techniques. When I toured the labor room with my childbirth education class, I realized that even though I might want a natural birth, I would not be able to move once I was hooked up to all the monitors. At the hospital I would be lying on my back in agony, and I would want something to help me through the pain.

Well-meaning doctors and hospital staff often push interventions onto laboring mothers. Because they are equipped to administer medical pain relief and typically are uneducated in

natural birth strategies, some staff members offer medication repeatedly, even when the mother refuses (Harper, 1994). Then, in their haste to help the suffering patient, they often fail to acquire informed consent from mothers prior to performing interventions (Epstein, 2007). According to federal law, doctors must inform patients about an intervention and all associated risks (Flight, 2004). When doctors administer Pitocin without informing the mother that the drug raises the risk of fetal distress, they are infringing on the rights of their patients (Flight, 2004). This withholding of information, no matter the reason, limits the mother's access to self-determination, and it should only occur in cases of extreme emergency care. When labor interventions are used without informed consent, the mother may not know that her medical choices are placing her and her baby at higher risk for injury and death. In this way, the obstetrician's failure to explain the risks causes the patient to consent to interventions that often lead to injury.

Women are not being provided the necessary information to give their doctors informed consent, and they are making fear-based choices that lead them into a dangerous process. In these ways, the mainstream maternity care system limits the power of mothers to safeguard their rights, but what about the rights of the babies? When I learned about the medical effects of epidurals, I realized that it would be wrong to relieve my own pain at the expense of my son's health. Many women do not know that they negatively affect their babies by medicating during labor. Yet, all drugs used in obstetrics have some toxic effects on babies, effects that may last from several hours to several weeks and beyond (Harper, 1994). Babies' brains are highly susceptible to damage from drugs, and drugs have a stronger influence on babies because of their size and limited liver function. In addition, babies who are exposed to drugs during delivery risk

damage to the central nervous system, diminished sensory and motor responses, and problems with feeding, sucking, and rooting (Jordan, 1993).

Once the baby is born, infantile withdrawal from narcotics can last up to two weeks after birth. Because a baby's liver is not fully functional, the body takes longer to metabolize the drugs, and the baby may not be receptive to bonding attempts (Harper, 1994). The Pennsylvania Supreme Court ruled that unborn children have individual rights, including the right to be free of prenatal injury (Flight, 2004). By that count, thousands of babies every day are having their rights infringed upon. The irony is that the medical staff members who administer the injurious treatments are trying to preserve the health of the baby after multiple unnecessary interventions create a health crisis.

For me, following my instincts was my first step in safeguarding myself and my baby. I feel lucky that I left the hospital system before I went into labor, and became stuck. Many women are in the middle of labor before they realize that they are giving away control of their childbirth. Many do not realize until much later, while others never understand that they gave up their right to self-determination in what could be the most profound right of passage they will ever experience.

I went into my pregnancy believing I had all the information I needed. I had been socialized to believe that a medical approach to birth was the safest option. My arrogance, my belief in my own competence, and my stubborn resistance to the example set by my mother precluded any possible questions. I considered myself tough, a survivor, and a smart woman. I was many things, not the least of which was critically uninformed. When questions did finally find their way to my lips, I was ignored, and laughed at. During my pregnancy, for perhaps the first time in my life, arrogance gave way to humility. I had to admit that I was afraid, that I was

facing a great unknown, and that I felt alone in my depth of concern. I finally had to learn about an issue and make some tough decisions about how to be a mother. Humbled yet resourceful, I found the support I needed. Then I searched for the answers. What I have learned is staggering. The knowledge has shaped my worldview, and it has come with responsibility.

Now, I am dedicated to giving power back to women in the birthing process. I believe that an effective way to empower our new mothers is to provide a case worker for every woman throughout the course of her pregnancy, labor, and postnatal period. This case worker would serve as the ethical shepherd of the process, ensuring that women know their rights and are connected with every available resource. The case worker would serve as an independent source of knowledge as well as a watchdog for lacking or dysfunctional services. Since the birth of my son, I have re-entered college so that I can help develop a support system for our nation's women. I do not intend to tell women definitively what choices they should make. However, I will ensure that they fully understand the implications of their decisions and that they are treated with respect and consideration by medical professionals. Knowledge is power, and it is time that American women are empowered in our maternity care system.

I began my pregnancy in a state of resistance, arrogance, and ignorance. The journey through pregnancy and birth stripped from me everything I thought I knew and taught me something more important: I am strong, and I am wise. I have since endeavored to add knowledge to that strength and wisdom, and I move forward with purpose that comes from within me. People often say that nothing changes a woman like motherhood. That concept does not begin to describe the transformation I have experienced. I finally understand that in relinquishing my struggle to avoid my mother's influence, I discovered a freedom that she never

found. Once, believing I knew the answers, I ran from my past. Now, with joy that emerges from personal growth, I walk toward my future.

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