Post Traumatic Stress Disorder is an anxiety disorder that can develop after exposure to a terrifying event or ordeal where grave harm occurred or was threatened (i.e.: to the women and/or her baby). PTSD is one of the most serious effects of trauma. We are familiar with PTSD in torture victims, combat soldiers, sexual assault victims and war survivors but PTSD after childbirth has a long history of dismissal. Current estimates of the number of women who develop all symptoms of PTSD after childbirth are about 6-7%. [Beck, C Birth Trauma: In the Eye of the Beholder Nursing Research 53(1):28-35 Jan/Feb 2004]. Far more women develop some of the symptoms of PTSD. All of these women suffer birth trauma. An Australian study found 1 out of 3 women reported a stressful birthing event with three or more trauma symptoms when interviewed 4-6 weeks after a vaginal delivery. [Creedy et al Childbirth and the Development of Acute Trauma Symptoms: Incidence & Contributing Factors Birth 27(2), 104 – 111] To put this into perspective, the rate of PTSD in the regular Canadian Forces is estimated to be 2.8% overall and 4.7% in soldiers with 3 or more deployments. [Canadian Community Health Survey: Canadian Forces Supplement on Mental Health 2002]

Women traumatized by their birth experience can experience both acute and chronic (life-long) trauma symptoms.

Symptoms of PTSD include:

- Re-experiencing aspects of the trauma (nightmares, flashbacks, intrusive memories)
- Avoidance of anything likely to remind them of trauma (TV shows about childbirth – however unrealistic, medical professionals, necessary medical care)
- Hyper vigilance - sudden startle reactions, anger, inability to trust, being ‘on guard’ for other situations that could be hurtful

People who suffer trauma symptoms can also have insomnia, emotional detachment (tuning out), loss of libido and the inability to enjoy aspects of life that were enjoyable before. When talking about traumatic childbirth it is not unusual for women to use the same language as sexual assault victims. They talk about violation, assault, invasion, torture and rape. A more complete list of trauma symptoms is included on the ‘HELP’ page. Unresolved pain is only one reason (but a VERY big one) women develop post partum psychological trauma symptoms. Loss of control – which will be lessened with timely and effective pain relief they can control – a lack of respect for her privacy, dignity, and choices and having to cope with life-altering negative health problems are all ways women are traumatized before, during and after childbirth. Pain, loss of control and lack of respect, privacy and dignity (or any dehumanizing treatment) and serious health problems cause post traumatic stress in ANY human being - male or female.

Chronic stress leads to physical problems: decreased resistance to infection, heart disease, headaches, immune system problems, chest pain, shortness of breath and gastrointestinal problems to name a few. Alcohol and substance abuse are common coping mechanisms and depression is a common symptom as well. Depression and traumatic disorders are both normal, human reactions to trauma but they are distinct problems and they can co-exist. PTSD is often misdiagnosed as depression.

Birth Trauma Canada recognizes that loved ones who attend women during childbirth can be traumatized as well. They often feel guilty for not protecting them or being better advocates. Sometimes this is justified and sometimes they are trying as hard as they can given the circumstances. Relationship breakdown is common after a traumatic birth experience.

A few of anonymously disclosed reports to Birth Trauma Canada:

I am 9 months postpartum with my first (and probably last) child. I had a horrific and humiliating experience. When I was 7 months pregnant, I developed urgency-frequency incontinence and a hyper-tonic pelvic floor due to the weight of the baby and his position in my body. After seeing a urogynecologist, I was coldly told there was nothing she could do. At this point I could
not work because I was having horrible bladder spasms, going to the restroom 40 times a day, and having at times severe pain and pressure. The OB kept telling me this was normal and not to worry. I knew enough to know this was not at all normal.

At my final OB appointment I felt water dripping down my leg. I asked my OB if my water broke. Without examining me, she said no, it would be a gush of water and I would know it. I later learned this was not true. My water had indeed broke at that moment. About 36 hours later, I felt something was wrong. Upon arriving at the hospital, I was told indeed I was in labor and would need to be induced to speed things along since my water had broke and there was the risk of infection. After 2 hours of pushing, a forceps delivery, my baby boy was born at last. He was immediately taken away and was ten floors below me for the duration of my stay. Thankfully, he was OK.

For the first six weeks thereafter, I was incontinent of bowel and bladder and had no control. I was told by my doctors to go home, change my own diapers, then change my baby’s. I was also told it would go away. Although it has gotten better, it has not resolved. I never ever dreamed that this could happen to me otherwise totally healthy 22 year-old. It has been the most degrading experience of my life. I realize one’s body changes with pregnancy and delivery, but to the degree that one loses basic human functions? I felt crazy and helpless – as though I was in a terrible dream and couldn’t wake up. I just wanted to sleep so I didn’t have to deal with real life. I wanted to run away. I thought about killing myself. The worst part was people would say at least your baby didn’t die, at least you don’t have cancer, think about those poor souls. You are the lucky one. When someone dies, you have support of friends and family, you mourn, you bury the dead – I should know after losing two loved ones in my lifetime. With the loss of your womanhood, everything that makes you feel special and beautiful, the loss of the ability to control your bodily functions, no one mourns, no one cares. It is all about the baby now. You have created a legacy, move over, you don’t count, you don’t exist.

I want women who go through this to know that they are not alone or crazy. When you read magazines they never mention the long-term health ramifications like bowel and bladder dysfunction following pregnancy. They want you to believe that it is all gummy bears and rainbows. Don’t get me wrong. My child is the love of my life, I just wish my OB had told me about the risks of forceps, prolonged pushing (especially in the traditional position), and induced labor.

When my sister delivered her son she had a horrible time. She started out with a midwife and a lot of confidence in her ability to have her baby without drugs. Her labour lasted 2 1/2 days before they moved her to a hospital. There they tried a vacuum extractor. That failed. Then they used forceps to pull the baby out of her. They had to cut her up very badly and then she tore even more. Her baby wasn’t in very good shape afterwards either. It hurt for her to sit and walk for a long time. She was so out of it she can’t remember stretches of time and she walked around like a zombie for many, many months afterward. She still isn’t the same person. She isn’t the same confident person she once was. When she needs to have a bowel movement now she has to insert her finger into her vagina to hold her rectum in place. She had to have another operation when her son was three years old so she can control when she urinates. Her husband left her for another woman when her son was a year and a half. She was happy to see him go. I always wanted to have children but there is no way I wanted to suffer like she has. No one can predict what awful things can happen. I opted for a planned caesarean.

My mother’s friend is a midwife (the same one my sister had) and she went ballistic when she found out I was planning on getting pregnant and having a caesarean. I wasn’t natural - They operate without adequate anesthesia - Epidurals will paralyze you - The infection rate is terrible in hospitals - It will take so much longer to heal - Surgeons will cut you where they shouldn’t. She terrified me. She sent me to an obstetrician who wanted to send me to a psychiatrist for wanting a caesarean. I left his office vowing never to have children.

But the desire to have children wouldn’t go away. I wanted a baby so bad. I just found a new family doctor and I talked to her about everything. She was so wonderful and supportive. She told me obstetrical politics were vicious and recommended an obstetrician with an excellent record. I went to him. He said the hospital he worked in had quality staff and top notch infection control. He had never had an infection with a planned caesarean. He assured me I would feel no pain during or after the operation. The anesthesiologists he worked with were all highly trained and competent. He never started surgery without their permission and I would be awake and aware the whole time. And no - he had never cut anyone where he shouldn’t and he had performed hundreds of caesareans. The surgery would take about 45 minutes and my baby would be born in the first 5 - 10 minutes of that. I would see and touch my baby as soon as the pediatric nurse finished her duties which wouldn’t take very long. People would talk to me and let me know what was going on throughout surgery. I would have my baby with me in recovery if I wanted and the baby didn’t need specialized care, which he assured me is highly unlikely.
So who do I believe? I was already 33 years old so I got pregnant and opted for the planned caesarean. I showed up at the hospital in the morning at the appointed time and I was very frightened. I admit being prepped for surgery wasn’t a good time. I’d never had a urinary catheter, an epidural or an IV before. I really felt like changing my mind when they strapped my arms down and out to the side and all those people in masks and gowns were around but I kept thinking about my sister.

So how did things turn out? I have two beautiful children now. My daughter is 5 and my son is almost three. Everything my obstetrician promised was delivered. I was up walking in about six hours with both children. I was out of the hospital on the third day but with both of them I think the last day wasn’t really necessary. I took oral pain killers for 3-4 days after I got home and I felt great. I did have a problem with hemorrhoids for about a month but I didn’t ever - and still don’t- have any urinary, bowel or pelvic prolapse problems. A planned caesarean may not be right for every woman but it was the right decision for me.

I’ve never talked about this to anyone but you. 27 years ago I had a miscarriage. I was 5 months pregnant when it happened. My husband (at the time) was out of town. I called my neighbour for help. I was bleeding heavily and in great pain. She had a two month old and wasn’t in very good shape but she was such a trooper for me. She had the next, next door neighbour look after her baby while she drove me to the hospital. She knew to bring towels to put between my legs and they were soaked by the time we got there. She tried her best to protect my privacy by leaving me in the car while she went for a wheelchair and whispering to the triage nurse what was happening. They still made me wait in the lineup in full view of everyone waiting in the ER. I waited for 30 minutes (bleeding and in agony) in that line. They took me to an area in ER but wouldn’t let my friend come back with me even though I wanted her. She was crying, she was so distressed for me. My last memory of her was of her promising to call my husband. It was the last time I saw her for a week and a half. They examined me and told me there was no hope of saving my baby and that I needed to let nature take its course. Then they left me without any privacy and without any pain relief. When I begged for it they told me I couldn’t have any without my husband’s permission. I was left like that for three hours before he could get back to town. I eventually ‘gave birth’ to my dead fetus and had a D&C. My husband, my family, my husband’s family and the nurses who cared for me told me my experience was of no consequence and that I should get pregnant again as soon as I healed. This was supposed to be the best remedy for my suffering.

I was haunted by memories of this for years. I still have them. The same goes for the nightmares. There isn’t a day that goes by that I don’t mourn for my loss. I regret not having a burial or some sort of meaningful ritual. I did learn a lot about myself and my place in the world though. I had a happy childhood and my parents raised me to believe I could be anything I wanted to be. I learned that the world doesn’t view me that way. Other things I learned were:

-when you are pregnant you don’t have the human rights you have when you aren’t pregnant
-when you are married you do not have the same human rights as single women
-you can have a fulfilling life without children and without a husband. I left my husband a year after this experience and I never had children. I haven’t been to a doctor since either.

I don’t think too much has changed in those 3 decades. My niece just had an emergency caesarean and they handed her baby to her husband first. They had to walk past her to do this. I don’t think anything says ‘you are second best and of no real consequence or value’ better than this.

I really need a listening ear. I was pregnant with my first child 11 years ago. I went to the clinic for my first appointment. This was not my first time having a pelvic exam etc. But this was the start of my anxiety attacks and frequent nightmares. A male doctor saw to me. (This isn't the problem, really). There was an elderly lady to chaperone. The problem is there were two student nurses observing. I didn’t know they were going to observe the breast and pelvic exam. If I had known, I would have spoken up earlier. When the doctor was conducting my breast exam, I was exposed from the waist down with only a paper towel covering me. This was very uncomfortable. I noticed the student nurses stifling their giggles. But I was struck dumb with embarrassment. Then when the doctor was conducting the pelvic exam, he was at my side. The chaperone was next to me. And the student nurses moved right to my feet. I was very embarrassed about being exposed in this way. What made it worse, was the student nurses seemed to find this procedure very funny and were trying their best not to laugh. I felt very degraded. And just like a piece of meat. For others to watch and ridicule. I wasn’t even asked for permission for me to be observed. To this
day, I go only to female doctors so I don't need nurses to chaperone. I have a great fear of witnesses as I feel degraded in their presence due to my past trauma. My heart aches till this day. I wish I could confront those 2 student nurses but there aren't any records of their names by the time I decided to do this. I wish I was more assertive. I'm deciding to forgive these 2 (childish) nurses. But it's not easy. Female exams are now very, very stressful affairs for me. Thanks for giving me a listening ear. This is truly the most traumatic episode for me. Many counselors have wondered what the big deal is. So I'm thankful for this episode to voice my feelings.

This past November, I terminated a pregnancy when tests showed severe chromosomal abnormalities. If I carried to term - which was unlikely - the baby would be born missing parts of the brain and part of the heart. 80% of babies born with this condition die in six months. Almost 100% die after a year. We decided that the kindest thing to do would be to terminate the pregnancy. I was astonished at the amount of negative reactions, when I told people the decision we'd made. Somehow, it's seen as more “natural” and “noble” to give birth to a child whose only purpose is suffering. I joined a mailing list for women who've had to make the decision to terminate for a “poor prenatal diagnosis,” as it's called, and the security on the list was amazingly tight. The reason, they told me, was that anti-choice wingnuts had joined the list in the past and gone on to harass members, some even going so far as to publish the names of the women along with contact info, so that they could be harassed more effectively for making the choice they did. When I posted about the results of the tests, and our decision to terminate, in a forum that is not political in nature, a member of that forum passed my name and email address on to someone who runs a prolife website. They told me it was nobler to give birth to a severely damaged child because of some theological tenet having to do with ensoulment or something. As near as I can parse the argument, which I've never seen explicitly stated, having a stillborn or newborn who then dies ensures that the “new soul” goes directly to Heaven, whereas apparently an aborted fetus doesn't. It doesn't make sense at all from a rational perspective, and just goes to show that the batshit crazy goes deeper than expected. I ended up closing that email account, which I'd had for years, as a result of harassment. The “life at any cost” crowd has no compassion or decency.

BTCanada

There are a number of negative aspects reported to us that cause or contribute to birth trauma before, during and after childbirth. Some of them are:

- Denial of or ineffective pain relief during labour/delivery, placental expulsion, sutured/surgical repair of genital tract trauma and post partum recovery. Pain during labour and delivery is extreme and excruciatingly painful. Pain after a vaginal delivery is also severe.

- Poor pain management during and after caesarean section

- Dissociative psychological symptoms and amnesia. This is called ‘baby amnesia’ when it happens during childbirth and it is extremely common. It is treated in a less dismissive manner when it happens to torture victims, combat soldiers, sexual assault victims and accident victims.

- Loss of control – both of bodily functions and medical treatment.

- **Lack of privacy and dignity.**

- Hostile, dismissive, sanctimonious and insensitive childbirth educators and medical personnel.

- Unwanted multiple caregivers during labour and **unwanted spectators during delivery.**

- Betrayal of trust and failure by caregivers and/or support person(s).
- Labour interventions – amniotomy, pelvic/vaginal examinations, intrauterine monitoring, induction/augmentation, IVs, urinary catheters, etc.

- Delivery complications – operative assisted deliveries (forceps and vacuum extractors, episiotomies), emergency caesareans after labour, shoulder dystocia, spontaneous or deliberate separation of pelvic bones, retained placenta, hematoma, uterine inversion, uterine atony, blood transfusion, hysterectomy to stop post partum bleeding, obstetrical shock, amniotic fluid embolism, etc.

- Obstetrical lacerations - both spontaneous (as the fetal head passes through the cervix and vagina) or deliberate (episiotomies cut by obstetrical caregiver), genital tract bruising and swelling and pelvic nerve damage.

- Prolonged or obstructed labour.

- ‘Short’ and rapid deliveries.

- Tetanic contractions.

- Infections of obstetrical lacerations and caesarean incisions (includes hospital acquired infections) Necrotizing fasciitis (flesh eating disease) and toxic shock syndrome are two of the deadliest. Women who don’t die of these diseases are severely maimed. [Claudia Mejia — quadruple amputee as a direct result of being infected by flesh-eating disease in the hospital delivery room in Florida.]

- Medical mistakes — Obstetrics is the specialty with the highest malpractice insurance rates.

- Not being listened to, being disrespected, being denied medical records (or given medical records that were clearly doctored), being denied explanations for care (or lack of), having birth plans ignored or disrespected.

- Sleep deprivation/maternal exhaustion.

- Guilt or pressure about delivery choices and breastfeeding choices.

- Sexual dysfunction – pain during intercourse, incontinence during intercourse, rupture of scar tissue, vaginal looseness, loss of sensitivity, loss of libido, fear of sex.

- Pelvic floor dysfunction – urinary incontinence, anal incontinence (both stool and flatulence), chronic pelvic pain and pelvic organ prolapse. These are often long term and chronic problems that young women (and women as they age) deal with or undergo further surgery to correct.

- Interference/ unwanted support by medical professionals and others.

- Dishonesty about realistic expectations and risks by childbirth educators, medical caregivers and other mothers.

- Discrimination by society and the medical profession against single mothers by choice, lesbian mothers and women who choose not to involve their partners.

- Difficult and complicated pregnancies. About ½ of all pregnancies involve some type of complication.

- Baby requiring stay in Neonatal Intensive Care Unit (NICU) or Special Care Nursery Unit (SCNU).

- Death of baby.

- Miscarriage.
“Your privacy isn’t important. Leave your dignity at the door. It is a good pain. Isn’t your baby worth it? These are things women are told to groom them for the entrenched status quo in maternity care. In my case it was not a man saying these things. It was not a man with his hands in my vagina ‘massaging’ it before the baby would stretch it beyond its limits. It was women.”

“I would like to share my brief story if I may. I am not a mother but I did take midwifery training. I quit in a moment of clarity when I realized I wasn’t cut out for the job. I lacked the desire to diminish women. I couldn’t desensitize myself enough to see normalcy in suffering and the appalling things done to birthing women. I couldn’t close my ears to the apologies and gratitude when they understood them and their babies had survived that sounded more like Stockholm Syndrome than genuine appreciation. I didn’t care that women who wanted epidurals and caesareans were decreasing our market share of a lucrative birthing business. I didn’t have the ruthless, competitive need to annihilate other women who were sexually attractive nor did I have the manipulative nature to do that in the sweetest of voices. I couldn’t listen to the behind the back gossip and comments about ‘teaching them lessons’ or ‘giving them a dose of reality’ or ‘ending their sense of entitlement’. I saw men be cruel to laboring, delivering and postpartum women but the women were the worst.”

“Normalizing the abnormal is how the wicked justify cruelty. Pain and damaged bodies are not normal, nor do they become ‘normal’ when the victims are women.”

“It is not just the traumatic bodily experience she is living through, but the simultaneous and incongruous reassurance that no trauma is being inflicted.”

(Quotes from random women on pregnancy and birth)

“Consider the failure on the part of society to comprehend the moral structure of the world as evidenced by the sanctioned immorality of the Christian Inquisition, the millennia-old failure of society to recognize women as persons, slavery, torture as ‘enhanced interrogation’, residential schools, etc. The list goes on. The abysmal treatment and attitudes toward women during and after childbirth, throughout time, present time included, isn’t just about misogyny. Sanctioned inhumanity can extend to all races and genders, although I do submit that most is directed at women.”

“A medical specialty that is hell bent on maximizing a woman’s suffering instead of minimizing it, who has the audacity to call that normal, who deliberately blocks advancement and who is unable (or unwilling – I don’t know which is more despicable) to recognize how immoral that behaviour is will continue to be a medical specialty I will avoid.”

“Misogyny towards women willing to mother is just plain stupid. Is there is a better way to ensure a low fertility rate and our eventual extinction?”

“If childbirth is supposed to be such a positive experience for a woman how come I’ve never heard any woman describe her child’s birth where it didn’t sound like a horror story?”

“I won’t have children because of my friend’s experience. It was terrifying.”

“Contraception has always been my best friend.”

“Never, ever again. Only a fool gets burned by the same match twice.”

“If women were told about the real extent of the damage done to them by vaginal births they would clamour for planned caesareans. I was never told what the risks of vaginal births were and I took all the prescribed courses to ‘prepare’ me. They never talked about it at all in my class. Some friends say it was mentioned in a dismissive, brief, round-about way in their classes. That is NOT informed consent. THAT IS NOT RIGHT.”
“My vaginal (first birth) was sanctioned sexual violence against women attended by those who got their jollies from that. My planned caesarean (second birth) was neither sexual or violent. Simple as that. If I had to do it again I would have had a caesarean with my first. The nightmares of that experience are still with me.”

“Lots of drama and a big production about ‘giving’ me MY baby. God, I hate those people. Such arrogance.”

The OB told my husband to hold me down as he couldn’t stitch me up because I was screaming and struggling because it was so painful. **And my husband did.** I’m supposed to be happy but all I feel is hatred for him, for the doctor and for the nurses who obviously were appalled by what was happening but didn’t do anything effective to stop it. I was raped. There is no other better word for what happened to me and every day I look across the breakfast table at one of my rapists. I have no money and a baby to care for so I can’t leave.

I had two midwives and I would not recommend them. They were cruel, sadistic bitches and liars too.

“**My Mom lives in an Alzheimer’s ward now. She hasn’t recognized her grandchildren for several months and she has to be reminded every time I visit who I am. She is also re-living the terror of her childbirth experiences. “This is something we see all the time”, said the nurses. They don’t tell you that in prenatal classes either.”**

“I am so ashamed of myself for being gullible enough to believe them. I have a PhD for Christ sake. I should have known better but I so badly wanted to believe them.”

“There is no better example of the blind, unmitigated hatred of women in obstetrics than the phrase “too posh to push”. No one else undergoing surgery would be subject ed to such brutishness.”

“**It is a lie that obstetric fistulas don’t happen in this country and only happen in developing countries. There are lots of us out there who know better.”**

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**Consider these statements:**

1) Cancer patients do not have the right to safe and effective pain control because pain is a natural consequence of cancer and cancer is a naturally occurring human condition.
2) Those in burn units who are directly responsible for their injuries have no right to effective pain relief or compassion. If they don’t like that choice they shouldn’t have burned themselves.
3) Encourage surgical patients to forego pain relief both during and post surgery. Instead, have a staff member providing one-on-one encouragement not to have effective pain relief. Patients should be encouraged to think of their suffering as ‘a good pain’, to ‘work with the pain’ and to embrace ‘an altered sense of consciousness’. Infer that anyone who wants pain relief is a weak minded failure. Encourage competitive suffering with post surgery get-togethers.
4) Hospital policy should ensure that all palliative care patients ask at least twice before their request for pain relief is considered. If death is imminent consider denying the request.
5) Trauma sustained during torture results in damaged bodies and damaged psyches. Depositing a large sum of money in their bank account will make them forget all about it.
6) Psychiatric studies show that pre-rape courses reduce the terror women feel during and after rape.

In a civilized society these statements would beggar belief, and with good cause. They are offensive, insensitive and cruel.

**Now consider the same statements when they are made about pregnant women:**

1) Maternity patients do not have the right to safe and effective pain control because pain is a natural consequence of childbirth and childbirth is a naturally occurring womanly condition.
2) Those women who get pregnant should not expect choice in delivery options, nor should they expect pain relief or compassion. If they don’t like that they shouldn’t get themselves pregnant.
3) Encourage obstetrical patients to forego pain relief during and after childbirth. Instead, have a staff member providing one-on-one encouragement not to have effective pain relief. Patients should be encouraged to think of their suffering as ‘a good pain’, ‘to work with the pain’ and ‘to embrace an altered state of consciousness’. Infer that anyone who expects effective pain relief is a weak-minded failure. Encourage competitive suffering with post birth get-togethers.

4) Hospital policy should ensure that all obstetrical patients ask at least twice before their request for pain relief is considered. If birth is imminent consider denying the request.

5) Trauma sustained during childbirth results in damaged bodies and damaged psyches. As soon as you put her baby in her arms she will forget all about it.

6) Psychiatric studies show that pre-natal courses reduce the terror women feel during and after childbirth.

These statements should beggar belief but they actually reflect obstetrical attitudes for the past several decades and, in many obstetrical circles (this country included), they are still widely accepted. Such attitudes maintain a deplorable status quo. They prevent advancement. Systemic discrimination always involves the attitude that a certain sub-group of the population is not deserving of humane treatment. They are considered inferior. What is considered unacceptable for other humans is considered acceptable for the group discriminated against. This is true for any form of systemic discrimination, whether it is based on race, ethnicity and, in this case, gender. Underlying all obstetrical bias is misogyny.

Only recently have some obstetrical associations around the world back-tracked from their long held views that childbirth is the only situation where patients can be denied pain relief, under the care of a physician, when safe and effective methods of pain control are available.

A) Childbirth is healthy

Childbirth is NOT healthy. It isn’t now and it never has been. I’m not sure if people who say this are being wilfully deceptive or just plain stupid. The end result is the same. Women are not well served by this bias. Women told this preposterous statement by people who know better, or should know better, have unrealistically high expectations about motherhood and the childbirth experience.

*When fertility rates go up so does the rate of women’s health problems. Parity is directly related to urinary incontinence, anal incontinence, uterine/vaginal/rectal/urinary prolapse, sexual pain and/or lack of sensation during intercourse, chronic pelvic pain and neurological problems throughout the body. Parity is also associated with heart disease, diabetes, gallstones, thyroid disorders, Alzheimer’s disease and a number of different cancers (breast cancer, renal cancer, etc.).* Having children for women is also associated with obesity – and all that entails. Women who have children have much higher unemployment rates and this puts them at higher risk for living in poverty. And don’t even get me started on the effects of stress. None of this stuff is healthy.

Ignoring or dismissing the obvious maintains the status quo and affords no hope for positive change that will improve women’s short term and long term health.

B) Childbirth is natural (and therefore good)

Nature isn’t just about fuzzy puppies and rainbows. Nature is also cruel, unfair and tragic. None of the people who espouse this obstetrical bias that I have met, to date, are willing to live in caves and forego the technological advancements that enhance their lives. Humankind exists solely because we can use our brains and ingenuity to counteract nature and none of us would last very long in nature. We can’t run very fast, we can’t see or hear very well, we have no body covering to protect us from heat, cold, insects and the sun’s radiation. We are susceptible to all kinds of infectious and non-infectious disease. The human body is not a superior design. We need our brains, ingenuity and technology to survive.

*Over 500,000 women die directly of childbirth every year. Most are in the developing world because they do not have access to life saving medical technology and qualified obstetrical care. Many, many more suffer life altering morbidity problems. In the developed world we have less maternal mortality and far more ‘near misses’. My point is that just because something is natural doesn’t mean it is safe.*

For those who feel that it is natural it must be good, consider all the things that are natural and definitely not good for you:
Tornadoes, earthquakes, tsunamis, mudslides, floods, hungry polar bears, any other predatory animal, spiders the size of dinner plates (Really. In Australia. Ewww), poisonous spiders, poison ivy, poison oak, any other poisonous plant, those big snakes than can crush you, HIV, tuberculosis, those ticks that carry Lyme Disease, mice that carry Hantavirus, any other infectious disease, marauding elephants, cyanide, arsenic, radon, hurricanes, death, botulism toxin. You get my point.

C) A healthy woman’s body knows how to give birth

Does a healthy man’s body ‘know’ not to have prostate problems? Does a healthy child’s body ‘know’ not to get cancer? To suggest they do is both ludicrous and cruel. Bad things happen to people everyday precisely because their bodies don’t ‘know’. As addressed above, the human body isn’t an anatomical wonder. Men have urethras that pass through the prostate gland – a gland that gets bigger as they age, restricts urine flow and has a strong tendency to become malignant. Some children are born with a pre-disposition to cancer and other sad genetic afflictions. It is not their fault. It is not a woman’s fault either when things turn bad during childbirth. We are the only species where birth involves pushing an infant that is too large through a space that is too small. There is no better way to make someone feel like a failure than to pump up unrealistic expectations about what their bodies are capable of. The role of medicine and technology is to address these inadequacies and to make us healthy and keep us healthy despite anatomical deficiencies.

Cemeteries prior to modern medicine are full of healthy young women and their babies whose bodies didn’t ‘know’ and who didn’t make it. These tragedies still happen today but nowhere near the same numbers. Today they are ‘near misses’. None of these women are failures. Those who don’t make it are tragic victims. Those who had near misses are survivors.

D) Childbirth is only painful if a woman thinks it will be painful.

Good grief. Childbirth is painful for the same reason kidney stones are painful or surgery without anesthesia is painful. Pain stimuli activate neurotransmitters responsible for pain. They transmit that information to the brain and the brain responds. Fear is an adaptive response to pain. Without this association we would never learn who or what to trust and what dangerous things we should avoid. Telling someone to relax while they are suffering immensely is maladaptive and counter-intuitive. It is another way to make women feel like failures. Why this bias developed with respect to women and childbirth speaks more about disregard for women than rational thought.

E) Non-pharmaceutical methods are effective pain relief

There are two effective ways to relieve pain. Both are pharmaceutical. The first is to prevent pain messages from reaching the brain (like a spinal and/or epidural) and the second is to mess with how the brain receives pain messages (like opium derivatives). The second way has serious drawbacks. Doses large enough to provide complete pain relief for the mother would kill the baby, and likely kill the mother. Any dose alters the mother’s perception of reality. Breathing techniques, water baths, massages, having someone in your face with ‘encouragement’ and going to your happy place do not relieve pain. They layer other sensations on top of pain or give you something else to think about while you are suffering. If these techniques actually relieved pain anaesthesiologists would be all over them in other areas of the hospital. You would read headlines like:

“Man passes kidney stones painlessly over three days, without morphine, relying solely on his Kidney Stone Passing support person and breathing techniques.”

“Anesthesiologists are shocked by pain-free open heart surgery performed without anesthesia in the Jacuzzi. Patient sipped herbal tea and chatted with the surgical team during surgery.”

“Anesthesiologists outraged that aroma therapists are replacing them.”

Not going to happen.

F) Childbirth is painful because women need to be punished for being women.
This is un-adulterated misogyny and still widely accepted.

**G) Women need to suffer to be good mothers**

Same comment as above. If this were true we wouldn’t hear from good mothers who didn’t suffer and from good mothers who did suffer whose babies serve as a trigger for traumatic stress symptoms and who struggle with the tremendous guilt that brings.

**H) Women need to reach an ‘altered state of consciousness’ to properly give birth.**

This ‘altered state of consciousness’ is dissociation and dissociative amnesia. It is a human response to severe psychological and physical stress and it should be avoided, not encouraged.

**I) It is a woman’s fault if she has a miscarriage or her baby has a birth defect. She must have done something wrong.**

15% of pregnancies end in miscarriage. 2-3% of babies born will have a birth defect. They are not caused by eating pineapple, having a glass of wine with supper, watching acrobats, bathing, full moons or any of the other preposterous and blaming theories out there. Heaping this kind of guilt on women who are struggling with pregnancy loss or struggling with the burden of coping with congenital defects in their children is indefensible.

Developmental biology is a complex science. There are numerous chances for errors during fetal development. A woman cannot control her genetics or those of her fetus.

**J) A healthy baby is enough to make up for the trauma of childbirth**

A prize, no matter how wonderful, does not cure physical or psychological trauma in any situation. Offensive statements like this isolate and further traumatize all trauma victims. Monetary compensation does not end PTSD for torture survivors. You don’t tell someone who has lost his legs that he should be happy he didn’t lose his arms. It is no different for women after childbirth. The experience of childbirth and the baby are two separate things. The attitude that a healthy baby makes women forget the trauma of their childbirth experience is patently untrue. Women carry that experience with them for life. Fatalism and stoicism are not the same as getting over it.

**K) “Caesarean surgery on demand will have disastrous social and financial consequences for health internationally”**

Blaming women who choose caesarean section for destroying the social and financial fabric is vicious. Heck, let’s blame them for conflict in the Middle East and pine beetle deforestation as well. It would make as much sense. Those with specific biases often use words like ‘empowerment of women’ and rail against ‘views not supported by evidence’, when they, as in this case, are guilty of the same transgressions. Scare mongering and manipulation are not empowering to anyone other than those wielding power. Denigrating those who don’t agree with your point of view is not respectful, to women or anyone else.

When I was first made aware of the source of this statement I was speechless. It is a direct quote from the Canadian Midwives Association found in their rant against maternal request caesarean section. I was not expecting such a visceral, inflammatory attack on a woman’s reproductive choice and autonomy from an association of women who fight so hard for a woman’s right to choose a less managed childbirth experience. We can’t blame patriarchal misogyny for this. This is blatant woman on woman abuse.

I want to make it clear that not all midwives think this way. I’ve talked to some who find this stance as repugnant as I do.

I strongly support a woman’s right to choose. Midwives have been maligned and controlled for centuries and I can’t blame them for feeling a bit scrappy. They provide a professional service strongly desired by some women who have every right to make that choice and that choice should be fully funded but a midwife-attended vaginal birth is not the only acceptable choice women can make. The choice any woman makes is the right one for her and should be respected, not denigrated.

**L) Episiotomies are necessary to protect the pelvic floor.**
This bias was once widely held. Millions of women around the world were subjected to routine episiotomies for decades in the belief that cutting the perineum would have a better outcome for the pelvic floor than spontaneous lacerations. Studies supporting this bias appeared in medical journals and doctors and nurses everywhere believed this. There was lots of information to support this stance but not a shred of credible evidence. That is the nature of bias. Deliberately damaging the pelvic floor to save the pelvic floor is as inexcusably stupid in hindsight as it should have been during the decades women were subjected to routine episiotomies.

M) If it is in a medical journal, it must be true. (Or how to recognize a spin doctor)

This simply isn’t true. Many medical journals (particularly with respect to childbirth) are propaganda vehicles for a particular bias. One estimate states that only 0.1% of all medical studies published every year can claim to be both scientifically sound and potentially relevant to doctors and patients. There are many days when I think that estimate is overly generous. Dr. Richard Smith’s The Trouble with Medical Journals [RSM Press, 2006] provides insight about this serious problem. Integrity in medicine remains as elusive (and worth fighting for) as integrity in any other business. There are people working hard to support genuine evidence-based obstetrical information, more humane treatment of pregnant women and factual accountability and transparency. More power to them. It has been, and continues to be, an uphill struggle.

How can you distinguish the bad from the good? It is a problem even those with an understanding of the scientific process struggle with. One of the first ways to educate oneself about the prevalence of obstetrical bias is to read archived obstetrical journals. With the benefit of hindsight the bias (and related misogyny) presented in many of these published studies practically jumps off the page. How do you recognize bias without the benefit of hindsight? I’ll take one study and dissect it to show what tools of deception are used. You can look for the same in other studies.

I’ve chosen ‘Maternal mortality and severe morbidity associated with low-risk planned caesarean delivery versus planned vaginal delivery at term’. It is authored and championed by the Public Health Agency of Canada; the Department of Obstetrics and Gynaecology, University of British Columbia, Vancouver; Perinatal Epidemiology Research Unit; Department of Obstetrics and Gynaecology and of Pediatrics, Dalhousie University; the Faculty of Nursing and Department of Obstetrics, Gynaecology and Reproductive Sciences, University of Manitoba; Departments of Pediatrics and of Community Health Sciences, University of Calgary; and the Departments of Pediatrics and of Epidemiology and Biostatistics, McGill University, Montreal. The lead author is Shiliang Liu. It was published in the Canadian Medical Association Journal (CMAJ) February 13, 2007.

Supposedly illustrious connections, to be sure.
Their conclusions were that planned caesarean deliveries (PCD) had higher morbidity rates than those associated with planned vaginal deliveries (PVD) when comparing healthy pregnant women at term.
This was a surprising conclusion to me. I have read many medical studies comparing PCD with PVD that arrive at the opposite conclusion – both in North America and around the world. The National Institute of Health (United States), in a statement about maternal request caesarean section, concluded that the quality of evidence available wasn’t good enough to say which was safer for the mother – an uncomplicated PVD or an uncomplicated PCD. How then, can different research scientists arrive at such diverse conclusions?

Rule #1 in recognizing bias in medical studies is: Are there other better designed studies around the world that dispute the study in questions’ conclusions? Could there be? Is there controversy about the conclusions or results?

Rule #2: Look for study design flaws.

The U.K. instituted thromboprophylactic guidelines for caesarean deliveries in 1995. Caesarean deaths (and morbidity) associated with thrombosis and thromboembolism declined sharply thereafter. (The Society of Obstetricians and Gynaecologists of Canada – SOGC – wouldn’t follow suit for another 5 years.) Other guidelines for better care of caesarean mothers were accepted and more widespread around the same time. [spontaneous vs. manual extraction of placenta, non-closure vs. closure of peritoneal layers, more reliance on regional vs. general anesthesia, etc.] Any study seriously comparing mortality and morbidity rates associated with PVD and PCD would ensure advancements were accounted for in your study period. This study purposely looked at 14 years of Canadian (except Quebec and Manitoba) retrospective data – from 1991 to
2005 - with the majority of planned caesareans prior to 2000. This is a perfect example of how study design can be used to mask bias and skew results.

**Rule #3: Look for what they aren’t telling you as much as you look at what they are.**

There is no better way to ‘prove’ your point of view than to ignore variables that don’t support your position. Let’s look at the stuff they aren’t telling us.

Maternal Mortality: This study concluded that ‘the difference we observed in in-hospital maternal deaths between women undergoing planned caesarean vs. planned vaginal delivery was not significant.’ (The emphasis is mine) In reality no women died in the planned caesarean group whereas 41 (0.02%) died in the planned vaginal delivery group. Are these deaths insignificant? I wonder if they would have considered these numbers insignificant if a similar percentage of deaths occurred in the PCD group and not in the PVD group?

How was maternal morbidity defined?

- **Hemorrhage requiring hysterectomy** (0.03% PCD; 0.1% PVD)
- **Hemorrhage requiring transfusion** (0.7% PVD; 0.2% PCD)
- **Any hysterectomy** (PCD 0.6%; PVD 0.2%) (not sure if this includes those women who had finished childbearing and required a hysterectomy for other medical reasons. It is certainly easier to do this at the same time as a caesarean. Requiring a hysterectomy after a vaginal delivery for the same reasons wouldn’t be captured in this data set as it would require a separate operation. None of this is mentioned.)
- **Uterine rupture** (0.3% PVD; 0.2% PCD)
- **Anaesthetic complications** (PCD 5.3%; PVD 2.1%)
- **Obstetric shock** (0.2% PVD; 0.1% PCD)
- **Acute renal failure** (0.04% PCD; 0.02% PCD)
- **Assisted ventilation or intubation** (0.1% PCD; 0.05% PVD)
- **Puerperal venous thromboembolism** (0.6% PCD; 0.3% PVD)
- **Major puerperal infection** (PCD 6.0%; PVD 2.1%) You can’t blame an uncomplicated, planned caesarean for puerperal infection. This is the result of poor infection control, lack of aseptic technique and substandard staff and hospital cleanliness and hygiene. Many hospitals have zero infection rates for planned caesareans. A rate of 6.0% is shameful.
- **In-hospital wound disruption** (PCD 0.09%; PVD 0.5%) This rate will go up if they aren’t done properly.
- **Obstetrical wound hematoma** (PCD 13%; 2.7% PVD) ditto

* Consider how these variables could change if the study period included only data after 2001 with the changes in obstetrical practice I’ve previously mentioned. This study also looked at planned caesarean deliveries for breech deliveries as representative of all planned elective caesareans but breech caesareans are more difficult than caesareans for cephalic presentations and would reasonably be expected to carry higher maternal risks.

What about the other variables they aren’t mentioning?

**Short term and long term health problems**
functions to take over. This part of the brain needs to take a back seat and allow the primal 'unthinking' part of the brain connected to basic vital functions to take over. A woman needs to be in a world where she doesn't need to think or talk.

**Maternal experience**

How did each individual mother feel about their experiences? What about the benefits of avoiding anxiety and pain of labour and delivery? Sedation, tranquilizers, anti-depressants and anti-anxiety pharmaceutical use is part of pregnancy and especially labour and delivery. How about a reduction in concern about the baby's health?

It is also worth mentioning that this study ignored the very real problem of doctor and hospital variations. Including statistics from rogue doctors and substandard hospitals misrepresents the ideal. The way morbidity was defined in this study would favour higher adverse effects for surgical deliveries than for vaginal deliveries given this reality.

**Rule #4 Was the study independent?**

Often medical studies are designed or paid for by pharmaceutical companies, medical device companies or people who would like to keep their jobs. There are a number of dirty tricks used to hide negative results in such cases. I don’t think that factored into this study but it is something you should be aware of when you look for bias in other studies.

Many reputable medical journals insist on independent statistical analysis of raw data as a means of reducing bias and maintaining integrity. This study did not have independent statistical analysis.

Censorship by publishers and editorial staff is another area that limits the integrity of some journals. Unless these controversies are exposed by someone with integrity and inside information or are picked up by a responsible member of the media these issues never see the light of day, yet they have a profound impact on what appears in medical journals.

As an example, consider the Canadian Medical Association Journal (CMAJ) and its recent struggle with editorial independence.

On February 20, 2006, Dr. John Hoey and Dr. Anne Marie Todkill, long-standing senior editors of CMAJ, were fired by the publishers – the Canadian Medical Association (CMA). The CMA had recently decided that their long-standing policy of making women come to them for post-coital contraception (levonorgestral or Plan B) violated a woman’s right to reproductive choice because of the barriers they had placed in a woman’s way. They made Plan B available without prescription. The CMAJ sent 13 women to buy the emergency contraceptive over-the-counter in pharmacies across Canada, and report their experiences. The pharmacists asked them for personal data, including the woman’s name, address, date of last menstrual period, when she had unprotected sex, customary method of birth control, and the reason for dispensing the medication. This was done at the recommendation of the Canadian Pharmacists Association (CPA), which also advised members to store the information permanently on their computers. Clearly the CPA had their anti-choice barriers in place. The Canadian Women’s Health Network (bless their hearts) said the obvious by stating that collecting this information was unnecessary and a violation of privacy. The CPA complained to the CMA, demanding that the names of the pharmacists be removed from the CMAJ article (bullies never like being exposed) and the CMA ordered the CMAJ to comply. The CMA then fired Hoey and Todkill, stating they wanted to ‘freshen up’ the journal. The rest of the full time editorial staff resigned on February 28, 2006.

The former editorial staff at the CMAJ launched a new open-access journal [Open Medicine] in April, 2007. The CMAJ went on to admit the episode raised serious concerns about the integrity of the journal and its reputation. Duh. I give them credit for laying the cards on the table and admitting mistakes. Positive change doesn’t happen without an initial admission of guilt. A warning posted on the CMAJ website by the editorial committee states “In our view, any attempt by the CMA to impose its influence on the editors would be catastrophic for the CMAJ’s reputation as well as damaging to the reputation of the CMA.” Too little, too late?

Such bad behaviour by the CMA and CPA isn’t restricted to Canada. Censorship and medical integrity issues are serious problems being addressed (hopefully) around the world.

This cautionary tale highlights the problem of medical solidarity at all costs and it influences what you will see, and just as importantly, what you won’t see in medical journals.

**N)** "A laboring woman needs first to be protected against any stimulation of the thinking part of her brain - the neocortex. This part of the brain needs to take a back seat and allow the primal 'unthinking' part of the brain connected to basic vital functions to take over. A woman needs to be in a world where she doesn't need to think or talk.
This chauvinistic endorsement of trauma induced dissociation is widely quoted by several (but not all) who champion 'natural' childbirth. Statements like this are from that past era where women were encouraged 'not to worry their pretty heads'. Being in a world where you are actively encouraged not to think or talk sounds like a setting for some B grade horror movie. Not thinking is a bizarre strategy to champion for thinking, feeling humans. I haven’t met a woman yet who wasn’t an intelligent, thinking, feeling type. My advice to any woman contemplating pregnancy is to put that thinking neocortex into overdrive, not shelve it. You NEED to think and gather as much information as you can to make an informed decision that is right for you. It is vital that you think. Thinking is not a bothersome affliction. It is not something you should turn off, or accept having turned off, through pain and humiliation induced dissociation or mind altering drugs.

o) "Epidurals will hurt your baby"

There is no more creepy or insidious (and highly effective) way to manipulate women than to use their maternal love and concern for their child as a weapon against them. You can force women to accept all manner of horrors if they feel they are doing it for their baby. That is exactly what this bias is. Mother love should be respected as the beautiful thing it is and not used as an excuse to hurt mothers. There is no credible evidence to support this bias. There has never been any credible evidence to support this bias. There will never be any credible evidence to support this bias because it is not true.

P) “No pain, No gain”

Unless you view labour and delivery as an extreme sport – and some do – there is nothing about this bias that serves women well. Denying effective pain relief to woman during labour, delivery and the post partum without a scientifically valid reason – and there really isn’t any - is misogyny. Despite this it is still a widely held bias.

Q) “Vaginal births are safer than planned caesareans”

“Planned caesareans take longer to recover from than spontaneous vaginal deliveries”

If either of these were true we wouldn’t hear so many stories where the opposite was true. If either of these were true many obstetricians, anestesiologists, nurses and others with access to inside information wouldn’t choose a planned caesarean for their own deliveries or those of their loved ones. If this were true the vast majority of horror stories we hear about wouldn’t be about planned vaginal deliveries. And if this was true most of the medical malpractice suits filed against obstetricians, midwives and hospitals wouldn’t be about planned vaginal deliveries.

R) “Evolution/Nature wouldn’t make childbirth dangerous.”

People with this bias have a poor understanding of evolution. They assume that the end product of evolution is better than the starting point and that maladaptive traits are eliminated as generations go on. I’m not saying that natural selection isn’t a powerful and effective force. It certainly is and it isn’t a very pretty process. Human technology shields us from the full effects of natural selection. Left to the unchecked processes of natural selection (like getting rid of modern shelter/medicine/optometry/dentistry, etc.) most of the human population, regardless of gender or age, on earth right now would die, including those with a poor understanding of evolution. I wouldn’t last very long myself. Letting natural selection run amok is the last thing a civilized human society would, or should, allow. But even if we did evolution would not eliminate all maladaptive traits. It wouldn’t even eliminate all the stuff that doesn’t contribute anything. Our own human genome is ample evidence of that. Most of the DNA in each of us is evolutionary baggage. It doesn’t code for anything yet we replicate the whole shebang every time a cell divides.

Mutation is a spontaneous process that can occur during cell division/DNA replication. This can happen during cell division (meiosis) or during human growth and maintenance that occurs constantly in people of all ages (mitosis). Cell division is a fascinating, elegant and complex process that is prone to errors, as all complex processes are. Most mutations are bad or neutral. Very few give an individual an advantage. All the positive attitudes about evolution and nature in the world will not stop this.

Chance – blind, dumb luck or the lack thereof – also influences evolution. It doesn’t matter if you are the strongest, healthiest person around - if you are covered in a mudslide, drowned in a flash flood, swept up in a tornado, killed in a car accident, whatever, and you haven’t reproduced you obviously aren’t going to be evolutionarily successful.
Consider how many maladaptive traits are carried through from one generation to the next, even though those with the disease generally don’t reproduce. Cystic fibrosis, hemophilia, muscular dystrophy, colour blindness are but four examples. There are plenty more. Consider our evolutionary vestiges. We have a tail bone but humans don’t have tails. They would look darned stupid and they would make finding a pair of jeans that fit right even more difficult and we don’t need them. Our early evolutionary ancestors did and it gave them a survival advantage. Evolution hasn’t rid us of this or any other trait we no longer use. A trait will continue in any species as long as enough people have that trait AND it doesn’t kill more individuals than can survive with it. Put another way, evolution allows certain traits to continue because they don’t reduce fitness enough. As well, many maladaptive traits aren’t even seen until after reproduction occurs.

Evolution is measured in the number of reproducing offspring – not lifespan or quality of life. Evolution doesn’t give a whit about whether the individual likes it. Consider the lives of two women. The first was a happy camper who was very rarely sick. She died at 100, not because she had anything terribly wrong with her. She was sharp as a whip and still active. She was hit by a bus because her recent limited mobility didn’t allow her to move out of the way in time. She never had children. Another woman dies at 62 of complications from diabetes. She also had moderate dementia. Life had been hard for her, as one would expect. She had two children who both had children. It is this woman who was evolutionarily successful, not the first. It is her genes passed to the next generation.

Evolution will not eliminate any trait that is required for survival in another capacity. Evolution will never act to reduce the size of the human head because without our increased capacity for intelligence we couldn’t survive. Evolution will never act to increase the size of the human pelvis because to do so would negate, or seriously limit, our bipedal mobility which would clearly not be advantageous to survival. Bipedalism requires the legs to be close enough together so the person can walk and this limits the size of the pelvic opening.

This would be a good time to also consider cultural pressures on evolution. Two women walk into a bar. The first is stunningly beautiful. She is tall and slim with large breasts and a beautiful face. The other is tall, with moderate sized breasts, a little plump, a beautiful face but her hips are huge. She has a tough time getting on the bar stool. Both are wearing the same outfit. Which one do all the men in the bar want to go home with?


S) “Millions of women have given birth vaginally, so you can too.”

Those with this bias never complete that thought process and see the bigger picture. Certainly millions of women have given birth vaginally and survived. And millions of them haven’t and many, many more have survived but with negative consequences.

T) “I had a vaginal birth without drugs/ planned caesarean/ vaginal birth with drugs/ suffered terribly/ etc. and you should too.”

People with this bias have what I like to call Centre of the Universe Syndrome (CUS). The afflicted suffer from the delusion that, as the centre of the universe, everyone must do and think exactly as they do and think. Of course, this affliction isn’t concentrated in obstetrics and it certainly doesn’t affect only women. Recently, at an office, I witnessed two men fighting over the best way to put a cutting board into the dishwasher. Both insisted their way was the best way and the fists were ready to fly. A wise and diplomatic co-worker suggested that, at each of their houses, they could put the cutting board in their dishwashers the way they wanted but maybe it would be best today to wash it in the sink. Three perfectly acceptable ways to get the job done.

Everyone has their own opinions and beliefs. They are the product of their own experiences. A person’s fears are a valid part of who they are. What works for someone doesn’t make it suitable for someone else. We are the centre of our own universe but we are not the centre of anyone else’s.

U) “A baby is worth the terrible suffering”

I wonder if people who have this bias think that babies that didn’t result in terrible suffering and maternal injuries aren’t worth it?
V) “Countries with some of the lowest perinatal mortality rates in the world have caesarean rates of less than 10%. There is no justification for any region to have a rate higher than 10-15%”.

These two sentences are the only basis for the oft quoted rationalization for reducing caesarean rates to this level. It is from the World Health Organization (WHO) in a one page letter to The Lancet in the August, 1985 issue. What one sentence has to do with the other is a mystery to me. It is worth remembering that the continued and shamefully high maternal death rate around the world – particularly in developing countries and in spite of WHO rhetoric – is not because of planned caesareans. They occur during and after planned vaginal deliveries.

Caesarean rates have no bearing on increased mortality rates. Sierra Leone has the highest maternal mortality rate in the world (at 2000/100,000 live births) and an extremely low caesarean rate and I would definitely recommend keeping Sierra Leone off your radar if you are looking for places to book a planned caesarean. Iceland has the lowest maternal mortality rate in the world (at 0/100,000 live births). Iceland’s caesarean rate is around 20%.

There are a number of reasons attributed to high maternal mortality rates. The number one reason is poor quality of care and that is true whether you are talking about vaginal or caesarean birth. A whopping 40% of all maternal deaths in the US are attributed to this and are entirely preventable. That they are not is shameful. The vast majority of maternal deaths around the world occur for three major reasons – post partum hemorrhage, infection and obstructed labour. Post partum hemorrhaging is actually less of a risk with planned caesarean and is not a high risk factor for mortality in any country with the ability, or the political will, to offer blood transfusions to women. Infection is not a killer if aseptic technique (and that isn’t rocket science) and antibiotics are available. Obstructed labour is not a killer if access to humane, qualified and competent obstetric surgery (caesarean) is available.

In developed countries maternal mortality is also linked to things like more mothers living with chronic and serious disease (like diabetes) and rising obesity rates. Maternal mortality rates also appear to increase when there is a change to better reporting methods, a recent change in the US.

W) Women can’t be misogynists.

Yes, they can. History is littered with female misogynists walking in lock step with their male counterparts. Every step forward in respecting human rights for women throughout history has been a long battle and much of the worst resistance has come from other women. This isn’t a flaw seen only in women. Rosa Parks was subjected to abuse and calls to back down and mind her place by other black people – women and men - when she famously refused to sit at the back of the bus. The SS assigned other willing Jewish people – men and women - to subjugate those sent to concentration camps. It happens among oppressed people as a means to survive both physically and psychologically.

Let me introduce you to Louise Silverton. Her attitude toward women proves we haven’t exorcized that reality today. I reproduce her words below. She made these comments in 2008. Louise Silverton is the secretary-general of the Royal College of Midwives (UK). (or the Head Matron at “The Let’s Keep Things Medieval School of Midwifery”. I can never keep those two entities straight.)

“An increasing number of women under 40 are less prepared to undergo the physical trauma of childbirth than their predecessors. Women under 40 were more likely to have an ‘epidural in a way that their predecessors wouldn’t’.”

“Labour is ‘unbelievably painful’”

“Women should be charged a fee for an epidural in an attempt to reduce women’s access to pain relief.”

‘Society’s tolerance of pain and illness has reduced significantly. Women are less tolerant of labour pains because they haven’t developed tolerance of pain. For example, if they get period pain they will either take Nurofen or go to their GP.

‘Women are trying to remove the symptoms of pregnancy as much as they can. They are seeking to control everything. Choosing to have a caesarean gives you an element of control.’
"I want Britain’s rate brought closer to the 15 per cent recommended by the World Health Organisation. Caesareans have been normalised in the minds not just of women but also midwives and obstetricians."

"The celebrity culture of having a baby and two weeks later being seen in a slinky dress, having lost weight, is affecting women’s views of caesareans."

"Caesareans have become too easy to obtain"

Her battle against modernity only serves to make her irrelevant in the modern world. And this is a modern world. Those ‘under 40’s’ she refers to are the first generation of women to most fully reap the benefits of an emancipation process that began over a century ago. They are the first generation of girls raised in the Western world to believe they are not second-class citizens and they take that basic right for granted, as well they should. They are not second-class citizens. We have, thankfully, not remained stuck in a world that banned women and girls from career options, higher education, the right to own property, the right to vote and participate in political processes, the right to drive a vehicle, the right to wear pants, the right to contraception, the right not to marry, the right to have a bank account, the right to pick our own partners and the right to be considered people. It is well past the time women were considered first-class, valuable citizens in obstetrics as well.

There are several questions I’d like to ask Louise Silverton. Why do you need to control women? Why does it bother you to see women trying to control their childbirth experience? Why do you need to see them suffer? Why a fee for epidurals? Do you hate poor women more than you hate rich women? Or are poor women just easier to control? Why does it bother you so much that women are ‘wearing slinky dresses, having lost weight, two weeks after a caesarean’? If midwives were allowed to do caesareans and epidurals would your attitude change? Why do you think your version of ‘normal’ should be everyone’s version of normal? Any other ways you want to toughen up girls besides shaming them for going to their doctor or taking pain killers for period pain?

As a young school girl (mid 1970’s, rural Canada) girls and women weren’t allowed to wear pants. One September a new principal (a man) changed all that. I remember looking out the school window with all the other youngsters as five middle age and older women emerged from the car they were chauffeured in. (Women couldn’t drive then either). They marched up the sidewalk, each one trying to look more virtuous than the other, intent on setting this man straight and protect the next generation of girls from…well I’m not sure from what. He did not back down. Several letters were written to the municipal paper disparaging him and his decision as well as disparaging girls and women for wearing pants – and gasp – driving a car. They were called sluts and whores and loose women. He still did not back down but some of the girls brave enough initially were forced by the hatred leveled at them to wear dresses and accept rides. Because of his courage and the courage of some women in that community girls in that backward little town have had the right to wear pants and drive ever since. So what happened to those five furious women? One went to her grave about 10 years later refusing to wear pants or drive a car. Today the other four are too embarrassed by their behavior to talk about it. All of them drive and wear pants.

Midwife Silverton (and her ilk) should take a relaxing drive in her car and buy a new pair of pants while considering all the reasons she could be wrong. Considering how history will judge her isn’t a bad idea, either.

Mickey Meece reports in the New York Times [May 9, 2009] that “It’s probably no surprise that most bullies are men, as a survey by the Workplace Bullying Institute, an advocacy group, makes clear. But a good 40 per cent of bullies are women. And at least the male bullies take an egalitarian approach, mowing down men and women pretty much in equal measure. The women appear to prefer their own kind, choosing other women as targets more than 70 per cent of the time.”

The role some men play in undermining human rights for women is well documented. It is a far more difficult conversation, from a feminist perspective, to acknowledge the unpleasant reality that it is often women who are their own worst enemies. Those mean girls from high school don’t go away when they become adults.

I, like many women, have preferred to ignore this reality for too long, despite being reminded on a near daily basis, that much of the abuses of women in obstetrics are done by other women. Knowledge is the best defence and we can’t continue to stick our heads in the sand about this, as I have. Phyllis Chesler, thankfully, doesn’t have my limitations. She has written a thoughtful, intelligent book from a feminist perspective entitled Women’s Inhumanity to Women [Lawrence Hill Books, 2009], that has helped me more fully understand why some women behave this way.

X) “Women are masochists”
“The traits that compose the core of the female personality are feminine narcissism, masochism and passivity.” [Willson, Beecham and Carrington, Obstetrics and Gynecology, 4th edition, 1971]

“The current generation of entitled young women come to labour unprepared for the experience and expecting it to be easy, or expecting the work to be ‘done for them.’” Anonymous Canadian obstetrician, 2008

The first quote was taken from the gold standard of obstetrical textbooks in the 1970s. The wording of that nasty bit of misogyny was softened in later editions and removed completely by the 1990s. Unfortunately, removing words doesn’t eliminate the attitude. The second quote about ‘entitled’ young women who have no right to a humane childbirth experience is just as chilling. We have a medical specialty where a significant percentage of practitioners believe that 1) women are masochists and 2) they aren’t entitled to be treated as anything else. Does it get any creepier? I don’t think so.

The human spectrum is pretty diverse. Undoubtedly there are some women (and men) who derive pleasure from their own suffering. If that is what floats their boat, so be it. But all women aren’t masochists. Aren’t now, haven’t been in the past and won’t be in the future.

Source: [http://birthtraumacanada.org/22.html](http://birthtraumacanada.org/22.html)