

The Assault on Normal Birth: The OB Disinformation Campaign

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We seem to have spent the last few years reeling from assault after assault on the concept of normal birth. Have you wondered, as I have, what is going on? Why is our side of the story nowhere to be heard? Why, for example, isn't the rising cesarean rate—which translates into about half a million unnecessary major operations per year at a cost of over \$1 billion to our health care system—considered newsworthy? Why are mainstream media rife with the grossest misinformation about cesarean section, VBAC, induction, epidurals—you name it—with nothing, *nothing* coming from our side other than an occasional tidbit tacked on in the name of balanced reporting, but clearly not meant to be taken seriously?

I think I have the answer: This isn't a matter of chance; it's a concerted effort. Here's what I think happened:

In the 1980s, as evidence mounted against typical obstetric management, obstetricians came under fire to change their ways. Simultaneously, malpractice suits soared. Obstetricians fought back—but not in any organized way, and with the tide of research against them, not very effectively. Somewhere in the early 1990s, they got wise. On the principle that "the best defense is a good offense," the American College of Obstetricians and Gynecologists (ACOG) decided that it would take a leaf from the book of other industries' image or litigation problems. Like cigarette companies, formula companies and the manufacturers of unsafe cars, it would run a PR campaign. This campaign had two arms:

- Sell the public on the idea that OBs are heroes, selflessly doing their best against difficult odds to safeguard the health and well-being and protect the interests of women and babies. Anyone who criticized or tried to rein in obstetric management then became the villains in the piece.
- Co-opt the research so that it could be used as a bastion within which obstetricians could continue business as usual. What is true in the popular press is equally true in the professional literature: If you "talk the talk," few will look behind the façade to see the weaknesses in logic or reasoning.

In short, I say that what we have here is a disinformation campaign waged by spin doctors, who, in this case, are real MDs. This may sound like paranoia, but, as the saying goes, "Just because you're paranoid doesn't mean they aren't out to get you."

When using the scientific method, you prove a hypothesis by showing how well it explains the facts. The hypothesis that does the best job wins, at least until one that does a better job comes along. I don't have any specific knowledge that this is what occurred, other than the fact that ACOG has a public relations department, but let's take my theory as a working hypothesis and see how far it gets us. Here are the pieces of the puzzle as I collected them. You decide if I assemble them into a convincing and coherent picture.

The *New England Journal of Medicine* Connection

I first realized that the assault on normal childbirth wasn't merely a series of sporadic events when I read the VBAC study and accompanying editorial that appeared in the *New England Journal of Medicine* in July 2001.¹ I was struck by the disparity between what the study said and the accompanying editorial.²

The study analyzed data on 20,500 Washington State women with previous cesareans. Researchers found that the risk of uterine rupture during a spontaneous VBAC labor was 5/1000, the same as other studies have shown, 7/1000 with oxytocin induction, but a whopping 25/1000 with prostaglandin (PGE2) induction. The risk in women planning cesareans was 2/1000, not far off the odds with spontaneous labor. An unbiased person would conclude that PGE2 inductions should be avoided and that primary cesarean introduced the risk of uterine rupture regardless of subsequent birth route.

The editorial, however, written by a *NEJM* editor, hammered home the dangers of uterine rupture during VBAC and how doctors and their professional organizations were "coerced or cajoled" into supporting VBAC programs. It concluded, "After a thorough discussion of the risks and benefits of attempting a vaginal delivery after cesarean section, a patient might ask, 'But doctor, what is the safest thing for my baby?' Given the findings of Lydon-Rochelle et al., my unequivocal answer is elective repeated [sic] cesarean section." This message appeared all over the popular press.

The editorial seemed odd to me because the *NEJM* is perhaps the most prestigious and highly respected of the research journals. Surely a physician who had achieved the rank of editor had to know that the study said nothing of the kind. For one thing, the differences in rupture rates were modest, provided you didn't use PGE2. For another, uterine rupture isn't the crucial issue—it's what happens to the baby as a result. The study didn't report this, but calculation using its data showed that with spontaneous labor, the odds of losing the baby were a very low 3/10,000. But more importantly, you can't determine the merits of VBAC versus elective cesarean by just looking at uterine rupture rates because there are complications that occur more frequently with cesarean. My own compilation of 30 studies comprising 56,300 VBACs and 30,000 elective cesareans found a 2/10,000 perinatal mortality rate in the elective cesarean group—no different from the study's VBAC PMR. How could someone who must be a senior scientist make such elementary errors of data interpretation and evaluation?

This raised another troubling thought: The article could have been written so as to bring these issues out. Other articles by the same group using the same database had been much more negative on repeat cesarean.³⁻⁵

Then I recalled that the *NEJM* had published several articles and editorials on obstetrics over the past few years that followed this same pattern—distorted interpretation of data, prejudiced editorial using loaded language, or both—and the light dawned. A cadre of Boston obstetricians was using the *NEJM* as a platform from which to advance their agenda. To review those articles:

- (1992) "Induction of labor as compared with serial antenatal monitoring in post-term pregnancy. A randomized controlled trial"⁶ This study was widely hailed as proving that induction at 41 weeks was preferable to expectant management. The study itself only claimed, contrary to many previous studies of induction, that cesarean rates were lower (20 percent vs. 25 percent).

Flaws: One-third of the expectant management group was actually induced, and one-third of the induction group actually began labor spontaneously, which would flatten out the differences between groups. A follow-up analysis in a different journal revealed that one-fifth of women in the expectant management group with spontaneous labor onset had cesareans versus a third of women who were induced. Among nulliparous women, 25 percent of women with spontaneous labors had cesareans compared with 40 percent of induced women.⁷ The question of why so many healthy women with term pregnancies and a singleton, cephalic baby in either group ended up with c-sections wasn't, of course, addressed.

- (1996) "Comparison of a trial of labor with an elective second cesarean section"⁸ "Major complications were nearly twice as likely among women undergoing a trial of labor."

Flaws: The only VBAC study to conclude that repeat cesarean had the advantage, it did so by coding wound infections and hemorrhage requiring transfusion as "minor complications."⁹ These would normally be considered major complications, and coding them as such would have wiped out the difference. Even

so, the major complication rate was a bit less than 1 percent in the elective cesarean group, a bit more than 1 percent in the VBAC group, hardly grounds for recommending elective cesarean.

- (1999) "The risks of lowering the cesarean-delivery rate"¹⁰ The authors argue that "economic forces are driving the cesarean-delivery rate toward the Healthy People 2000 goal of 15 percent" and that this "may have a detrimental effect on maternal and child health" because it forces OBs into doing VBACs to avoid repeat cesareans and vacuum extractions to avoid primary ones. The former lead to uterine rupture and the latter cause neonatal trauma, including subgaleal hematoma, a life-threatening hemorrhage. The authors further argue that we have no evidence for setting a 15 percent limit, and setting a goal at all deprives women of their right to determine their care. The editorial closes with the claim that cesarean delivery is cheaper than difficult vaginal birth, an accusation guaranteed to grab the attention of hospital administrators.

Flaws: We have ample evidence for what constitutes a reasonable cesarean rate. Any number of studies in inner-city clinic patients have documented that cesarean rates can safely be less than 15 percent.¹¹⁻¹⁴ National rates should be still lower because most women don't have the kinds of risk factors found among the poor—not to mention that the World Health Organization (WHO) deliberated the issue years ago and determined that cesarean rates should not exceed 10 percent to 15 percent.¹⁵ Nor has any research demonstrated benefits for a rate as high as 15 percent. Indeed, in 1980, the National Institutes of Health (NIH) convened a panel of experts to discuss lowering the cesarean rate, which had reached the alarming heights of—wait for it—15 percent.¹⁶ Finally, the editorial only presents two possibilities: more cesareans or more instrumental deliveries. What about door # 3? Striving for more spontaneous births would reduce both morbidity and cost.

- (2001) "Misoprostol [Cytotec] and pregnancy"¹⁷ This review admits Cytotec's adverse effects and equivalent cesarean rates compared with PGE2 or oxytocin but goes on to conclude that "There is ... strong and consistent evidence to support the use of misoprostol ... for induction of labor." The accompanying editorial, signed by two official representatives of ACOG, chastises Searle, the drug's manufacturer, and the FDA for opposing Cytotec's use. "The real victims," it states, "are pregnant women who receive treatment in hospitals that will not allow the use of misoprostol. Alternative medications are expensive [true] and relatively ineffective [a statement contradicted in the review itself]." It asks the FDA to "recognize the beneficial roles misoprostol can have," and closes with: "Women in the United States should not be deprived of access to misoprostol."¹⁸

Flaws: According to the FDA, Cytotec can cause, among other things, uterine tetany with marked reduction impairment of blood flow to the fetus, uterine rupture, sometimes requiring hysterectomy, amniotic fluid embolism, severe genital bleeding, shock, fetal bradycardia, and fetal and maternal death. Uterine hyperstimulation may increase the incidence of meconium passage and cesarean delivery.¹⁹ As regards superior effectiveness, a meta-analysis of randomized controlled trials of PGE2 versus misoprostol show that Cytotec produces virtually identical cesarean rates.²⁰ So much for indispensable and irreplaceable.

The research had always been the major obstacle to unfettered obstetric management. With the 1992 postdates study, obstetricians discovered they could conscript the research to serve their purposes. Quality didn't matter. As long as the study sounded good, it would pass regardless of obvious flaws. The credibility of appearing in a prestigious medical journal would wrap them in a cloak of invisibility. And if the study didn't quite conclude what you wanted it to conclude, that was OK too. Just have your spokespeople say that it did. No one will notice the discrepancy. Obstetricians haven't looked back since.

What Is Gained by Subverting the Research?

The *NEJM* provides means and opportunity, but what about motive? Appearing in the *NEJM* guarantees that ACOG's pitch will get widespread press coverage via the journal's PR machine. Even better, the infomercial will be packaged as news. Best of all, it won't cost ACOG a dime. You couldn't ask for a better

deal. But that's not all. The studies also give ACOG's flacks something to cite when writing supposedly evidence-based guidelines or fighting regulations:

The 1996 postdates management study and the Cochrane meta-analysis authored by the same group (which has its own serious defects) became the basis for the now standard practice of inducing labor at 41 weeks, which, by the way, is the average length of gestation in nulliparous women.²¹

The 1996 VBAC study is the only study cited as the rationale for ACOG's retreat from the pro VBAC position of its 1995 guidelines to its anti-VBAC stance in succeeding guidelines,²²⁻²⁴ although assuredly the 2001 *NEJM* study and the 2002 *JAMA* Scottish study will be cited in any future revisions.^{1,25}

Thanks, no doubt in part to lobbying based on the 1999 editorial on the dangers of trying to lower the cesarean rate, the new Healthy People goals no longer specify a target cesarean rate.

The Cytotec review was instrumental in the FDA's decision to retract its ban on Cytotec. Interestingly, though, the grounds weren't reassurance as to Cytotec's safety.²⁶ According to Reuters, "The contraindication and certain precautionary wording have been removed to reflect the fact that the drug is widely used to induce labor and delivery." In other words, the FDA decided to let OBs use Cytotec because they were using it. In fact, as noted above, the package insert still details the horrific things that can happen when women are given Cytotec to induce labor, but now the list is buried on page 8, and the warning icon of a pregnant woman with a circle and slash is gone.¹⁹

In addition, the usefulness of these studies and editorials in persuading the public goes way beyond the first news splash. They can and have been recycled again and again in subsequent articles in the popular press.²⁷

The Cytotec mêlée brought me to my next epiphany. Why were OBs fighting for Cytotec? You would think that anything with Cytotec's malpractice suit potential couldn't be repudiated fast enough, even if it did, as Marsden Wagner points out, allow OBs to practice "daylight obstetrics."²⁸ But aside from using it as a reason for repeat cesarean—"We need to induce you because (insert excuse here), but it isn't safe to do that, so you'll have to have a repeat cesarean"—OBs have championed it. Answer: If you can establish Cytotec as the standard of care, you are protected if you get sued for using it. Unlike the real world, "Everybody else is doing it" works in the legal system.

How do we know that this isn't an honest disagreement?

Any number of factors tells us that we aren't dealing with a legitimate difference of opinion. First, when people who should know better make fundamental errors in presenting research, ignore data that contradicts their theory or misrepresent findings, you can bet it's because they have an ax to grind. Oh, I grant you that most OBs believe that birth is a dangerous, damaging business and that they and their interventions are all that stand between pregnant women and disaster, but that's a distinction without a difference. True scientists have an open mind. And we have ample evidence that obstetrician researchers and spokespersons don't.

Mary Hannah, lead author of the postdates trial, is chairperson of a University of Toronto conference entitled "Choosing Delivery by Caesarean: Has Its Time Come?"²⁹

Michael Greene, director of maternal-fetal medicine at Boston's Mass General Hospital, who wrote the *NEJM* editorial on the dangers of VBAC, says of the merits of elective cesarean, "The in-laws get to use supersaver fares."³⁰

James Scott, who assisted in preparing the new ACOG VBAC guidelines, made his opposition to VBAC clear back in 1991.³¹ Small wonder that the new guidelines say nothing about the risks of elective

cesarean. In a telling bit of uninformed consent, they recommend only that women be counseled on the benefits and risks of VBAC.²²⁻²³ While the guidelines make much of levels of evidence, the main recommendation—hospitals shouldn't do VBACs unless they are capable of performing an emergency cesarean at any time, and an OB should be immediately available throughout active labor—is based on Level C evidence: "consensus and expert opinion," meaning of obstetricians. A *Lancet* editorial on practice guidelines disparagingly called developing guidelines without input from all stakeholders and a rigorous review of the evidence "Good Old Boys Sat At Table (GOBSAT)."³²

Charles Lockwood, chairperson of the OB/GYN department at the NYU School of Medicine, is also chairperson of ACOG's obstetric practices committee. Lockwood has been point man in ACOG's defense of the use of Cytotec: "Misoprostol's new labeling is a vast improvement over the previous version, but it remains 'overly alarmist,'" said Lockwood.³³⁻³⁴ He has also defended the doubling of induction rates over the past decade. In an ACOG press release entitled "ACOG Addresses Latest Controversies in Obstetrics" he said that the increase wasn't due to an upswing in elective inductions.³⁵ (I'll pause until you stop laughing.) No, the real reason was that "Over the past ten years a number of excellent clinical trials have suggested that various conditions, which were previously treated by observation, are better managed by induction of labor. (There's the 1992 *NEJM* trial again.) He added, no doubt to prepare the public for a continued rise, that the "bona fide" reasons to induce exceeded the number of inductions currently performed. He conveniently omitted the downsides of inducing labor. Chief among them, studies show that compared with spontaneous labor, primiparas run anywhere from half again to two and one half times the risk of cesarean section when electively induced, which means this is the risk attributable to induction itself.³⁶⁻⁴² That he could make these statements with a straight face confirms that "ACOG's finest" deal in propaganda, not science.

If you still harbor any doubts about this, consider that ACOG elected Benson Harer president in 2001. Harer along with his confreres used his bully pulpit to promote elective cesarean on the grounds that elective cesarean is just as safe as vaginal birth and vaginal delivery damages the mother.⁴³ Both statements are patent untruths. Cesarean section is demonstrably more dangerous for the mother, produces more complications in the short and long run, and barring certain rare situations, isn't safer for the baby either. It certainly isn't safer for future babies. Research indicts episiotomies, instrumental deliveries and, less unequivocally but highly probably, how women are made to push as the true causes of pelvic damage, not vaginal birth per se.⁴⁴ Pregnancy also plays a role, as does hysterectomy.⁴⁴

Second, arguments with logical disconnects are another tip-off. To cite some examples:

- Hospitals shouldn't do VBACs unless they are capable of performing an emergency cesarean at any time and an OB is immediately available throughout active labor.

This recommendation in ACOG's new guidelines sets a standard of care that cannot be met by many, if not most, hospitals. Even where it can, few OBs have the time for, or interest in, hanging out in the hospital for hours with a laboring woman. Since not following the guidelines would leave hospitals and physicians wide open in a lawsuit, the recommendation has wiped out VBAC in whole regions of the country. But as *Guide to Effective Care in Pregnancy and Childbirth* points out:⁴⁵

[T]he probability of requiring an emergency cesarean section for acute other conditions (fetal distress, cord prolapse, or antepartum hemorrhage) in any woman giving birth, is ... up to 30 times as high as the risk of uterine rupture with a planned vaginal birth after cesarean. ... Hospitals whose capabilities are so limited that they cannot deal promptly with problems associated with a planned vaginal birth after cesarean are also incapable of dealing with other obstetrical emergencies.

In other words, if a hospital isn't safe for a VBAC labor, it isn't safe for any woman to labor there.

- It's a woman's right to have a cesarean if she wants one.

If OBs were really for a woman's right to determine her care, they would be equally vocal in defending her right not to have a cesarean if she didn't want one, but see the previous bullet.

- Women want elective cesareans; we're just acceding to their requests.

Leaving aside ethical considerations of physician obligation to help patients make good decisions about their care, women don't spontaneously decide they want major abdominal surgery. Someone has to convince them that it's a good idea. That "someone" would be an obstetrician, a nice case of creating a market demand and then claiming that you are only responding to it. Studies confirm that women don't, in fact, want cesarean sections, but they can readily be manipulated into them by their doctors.⁴⁶⁻⁵⁰

- Labor is so painful that women are entitled to have an epidural whenever they want one even though having an epidural early in labor increases their chances of having a cesarean.⁵⁰

Cesareans are pain-free? There are no alternative ways to manage pain until labor is more advanced? Would women insist on an epidural if they knew they were increasing their chances of cesarean section? The gem above was the gist of a press release headed "ACOG supports epidural pain relief on demand" that decried hospitals making women wait until 4 to 5 cm dilation before having an epidural. Note the spin the title puts on the issue.

Finally, OBs have a self-confessed motivation for playing fast and loose with the truth: malpractice suit protection. Dr. Jeffrey Phelan developed the prototype for a so-called VBAC consent form now in common use.⁵² The form states that among other risks of VBAC, "I understand that if my uterus ruptures during my VBAC, there may not be sufficient time to operate and to prevent the death or permanent brain injury to my baby," but says nothing about the equally serious risks of c-section. Phelan openly admits in an explanatory editorial that the form was intended to forestall lawsuits and that using it will "send your c/sec rate soaring." The ACOG VBAC guidelines also cite malpractice protection as a reason for backpedaling from VBAC.²²⁻²³ This brings me to my last piece of the puzzle.

ACOG as Trade Union

ACOG positions itself as a professional organization advocating for the care that would best promote the health and welfare of women and babies. Throughout the 1980s and early 1990s, it had moved increasingly in that direction in many of its opinions and guidelines. Why the change?

The light bulb lit when I heard Marsden Wagner speak at the 2001 ICAN conference.²⁸ He said that ACOG was really a trade union. As such, its primary goal was protecting the interests and income of its members. If that happened to coincide with what was best for mothers and babies, well and good. If it didn't, it was women and children overboard.

I think that what happened in the 1990s was that ACOG's leaders woke up to the conflict of interest between promoting evidence-based care and ACOG's prime directive: benefiting OB/GYNs. They then deliberately changed course to wield ACOG's clout and credibility on behalf of OB/GYNs and to hell with evidence-based care.

Wagner went on to say that we shouldn't be allowing ACOG to regulate maternity care any more than we allow the auto worker's union to regulate car safety. I would take his thought further.

As regards safety, a better parallel than the AFL-CIO would be if tobacco companies had their scientists conduct research on cigarettes, they published studies concluding that smoking has benefits, they buried studies showing that smoking had hazards and then they wrote the rules that governed their liability in lawsuits. The situation is actually worse. Unlike what would be the case with tobacco companies, no one suspects ACOG or its academically credentialed obstetricians of an ulterior motive. Anything ACOG or its

minions say is uncritically swallowed whole. It's a sweet arrangement, although not, of course, for the women and children.

ACOG is now venturing overtly into the political arena. According to its [Web site](#), it has a new lobbying PAC. Be scared. Be very scared.

The Obstetric Hegemony

To return to the questions that opened this article, our side of the story isn't being told because ACOG's campaign has worked like a charm. As any ad agency exec—or snake oil salesman—can tell you, you can convince the public of anything if you say it loud enough, long enough and often enough. And if your message sounds scientific or comes from someone people trust—or better yet, both—you're home free.

This truth has enabled obstetricians to gain pretty much of a lock on the mainstream media. ACOG and the medical journals feed reporters press releases and provide them with handpicked experts for the color quotations. The reporters, article writers and editors take what obstetricians tell them as gospel and not only because they are doctors. Reporters and editors have grown to adulthood in an environment where one in five women or more has had a cesarean. They, their spouses, their friends and relatives have all had their babies with obstetricians in hospitals. Obstetric management feels normal and necessary to them.

The overwhelming dominance of the obstetric paradigm has further ensured the virtual silencing of dissent. When organizations or individuals opposing obstetric management try to get their point of view before the public, where do the reporters and editors go to evaluate the merits of the criticisms? You guessed it—those same experts and studies. In a game of "he said/she said," the one with MD after his or her name wins.

As for articles, nearly all article proposals that don't toe the party line will be rejected out of hand. The few that slip through will be gutted or killed. I don't exaggerate. I am aware of cases where this has happened, including my own. After three revisions to satisfy the editor that an article I wrote on Cytotec was bulletproof, the piece was killed because the magazine's lawyers decided there might be liability issues. From whom? Searle, Cytotec's manufacturer, which sent a letter to OBs warning against using Cytotec, would doubtless jump for joy at anything publicizing Cytotec's dangers. I'd take bets that the magazine's obstetrician advisor tipped off the lawyers.

So, have I made my case? In one sense, it doesn't matter. Conspiracy or not, the results are the same. You can fool most of the people all of the time. In another sense, it does matter. You can't begin to craft a strategy to fight back until you know what you're up against.

Henci Goer, author of *The Thinking Woman's Guide to a Better Birth* and *Obstetric Myths Versus Research Realities*, is an acknowledged expert on evidence-based maternity care. Goer has written consumer education pamphlets and numerous articles for magazines as diverse as Reader's Digest and the Journal of Perinatal and Neonatal Nursing. She appears on [ParentsPlace.com](#) as the "Birth Guru." Visit Henci's Web site at www.hencigoer.com.

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