

## Natural Birth

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*Human society is an antiphysis- in a sense it is against nature; it does not passively submit to the presence of nature but rather takes over the control of nature on its own behalf. This arrogation is not an inward, subjective operation; it is accomplished objectively in practical action [1].*

Firstly, let us agree that medicine is unnatural. The audacity to fight disease, prolong life, to interrupt physiology, defies nature. I have observed among expectant mothers and their families, a growing undercurrent of distrust with regard to the management of labor. The term “management” was aforementioned purposefully to underscore this pervasive perception that physicians want to manipulate and monitor an event which is spontaneous or natural. I believe this perception is fueled by escalating rates of cesarean birth which provokes anxiety in our patients.

As I’m writing, I struggle not to turn this into a manifesto, because actually, I am highly perturbed. I am quite bothered.

As our worlds become smaller largely due to the internet, mass media and such cultural phenomena as reality television, obstetricians must be more responsible to manage not only labor, but expectations and definitions. I recently assumed care of a patient who was very clear of her desire for “natural birth” as evidenced by the three-paged typed document affixed to her chart titled “My Birth Plan”. My philosophy has always been: baby comes out of the mama, *voilà*- natural birth. The patient, like I, had her own philosophy. In this situation, particularly with a patient I hadn’t had the opportunity to counsel, my first priority was to determine what natural birth meant *to her*. I read the plan.

In it, she expressed her desire for no medications, intermittent monitoring, eating/drinking at will, the supportive environment of her choosing which included specific people, music, and room lighting. All of this was to culminate in a vaginal delivery followed by direct skin to skin contact with the baby, delayed cord clamping, and immediate breast feeding and eventual delivery of the placenta.

She was a 28 year old primigravida at 35 weeks who had been diagnosed 12 hours earlier with severe pre-eclampsia and had a platelet count of 60,000. She also had an unfavorable cervix, consistent with her parity and gestational age. Despite her complexity, she remained steadfast in execution of her plan as literally as her condition and nursing protocols would allow. In fact, she was able to communicate the plan to the admitting team through a magnesium sulfate induced fog.

My first impression on entering the room was that it was dark and crowded. White, ambient holiday-like lights draped from the door to the mirrored sink area and finally across the back of the hospital bed making a semicircle resembling a shimmering crescent moon, at the center of which sat my patient. I was immediately impressed by the amount of planning and foresight that had to have gone into those lights, and considered this a sign of a person who cared about details and environment.

My second impression involved a twinge of claustrophobia. The nurse illuminated by the glow of her computer screen was enclosed on the far side of the room between the moon-bed and the wall. The patient’s husband occupied a pallet of blankets on the floor. Family members sat on the hospital provided couch and the doula sat beneath the lights on the edge of the bed coaching the patient, who by now had agreed to oxytocin augmentation.

As I introduced myself to the crowd, I was keenly aware of the doula acutely turning her back to me, grasping the patient’s face in her hands, muttering: “It’s your body; *you* tell *them* what you want to do.” I willed my brow not to furrow. I then stopped my intro mid sentence and approached the bedside to address the patient:

I am not your adversary. I am your doctor. I am here to ensure a safe delivery for you and your baby. We have the same goal.

I want to tattoo this on my forehead, to shout it from the mountaintops. Despite cesarean rates, lab tests and the imperfections of continuous monitoring, I believe the vast majority of physicians consider patient care and safety our top priority. If “natural” birth is success, to some women cesarean section may represent the ultimate failure. This disappointment has implications for the physician-patient relationship and more importantly the mother-child relationship, reaching beyond the birth, which after all, is a single moment in time.

Successful outcomes depend upon many variables, and success itself has meanings as diverse as individual women. One cannot expect low cesarean rates amidst rising rates of morbid obesity and its known sequelae: diabetes, hypertension, and vascular disease; nor in a community where tobacco and drug abuse remain pervasive problems; nor in a culture where advanced reproductive technologies enable women who under “natural” circumstances would never have become pregnant, to have the families they desire.

My patient delivered via cesarean under general anesthesia hours later. She and her child ultimately did well.

Our medical environment is changing due to the access to information for both doctors and patients. In addition to scientific, technical and interpersonal skills, tactics to counter the insinuation that we may not be advocating for the best interest of patients are needed. Knowledge we have all dedicated time, financial and personal sacrifice to attain has in itself value. Patients should know that medical opinions are not based on convenience, trend or popularity, but on scientific evidence which is reviewed systematically and routinely to develop guidelines and standards by which we all practice. Medicine is not serendipitous, nor careless. And good medicine is definitely not natural.

\*The demographics and details of the clinical scenario were modified to protect the privacy of the patient.

### References

1. Simone de Beauvoir (1940) *The Second Sex*. Women and Lit.

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