The Hidden Dangers of Hospital Births and How to Protect You and Your Baby

Unmasking the Business of Being Born

A MIDWESTERN DOCTOR
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Story at a Glance:

•Childbirth is one of the most important moments in our life. Unfortunately, it has been medicalized and has shifted from being viewed as a natural life event supported by local midwives to an emergency requiring urgent hospital care.

•Many of the interventions used during routine hospital births are quite questionable, and have a variety of side effects, including making you likely to need more interventions (which also have side effects) and having difficulty bonding with your baby.

•This assembly line frequently leads to mothers getting C-section surgeries—something quite problematic for both the mother and the long-term health of the child.

•This article will discuss the history of the business of being born, the actual risks of many common hospital birthing interventions, and how to reduce those risks.

•It will also provide strategies for choosing the best place to give birth, ensuring both optimal childbirth and recovery, and having a healthy child.

Many traditions throughout history have come to view the prenatal period and childbirth as one of the most important moments in a human's life as it sets the stage for all that follows. Unfortunately, much in the same way we desecrate the death process by over-medicalizing it (to the point research has found doctors are less likely to seek end of life care at a medical facility), the same issue also exists with childbirth. Many physicians I know who are familiar with the hospital birthing process chose to skip it and give birth at home (along with many more doctors featured in a 2016 documentary).

Conversely, a minority of childbirths do need advanced medical care, and for those mothers, access to a hospital greatly benefits them, particularly if actions are taken to mitigate the most dangerous aspects of hospital birth. As such, childbirth occupies a similar place as many other medical controversies; neither side of the issue is entirely correct. However, the discussion remains perpetually polarized because advocates on either side will not acknowledge the valid points raised by the other side for fear of weakening their own position. Since I feel strongly about the dangers of hospital birth, it is my hope in this article that I will be able to portray both sides of the issue fairly.

Note: I feel one of the most destructive trends in our society has been the devaluation of motherhood (e.g., when I visited China, it was striking how much more respect and consideration they gave to pregnant women) and children. Beyond new life being necessary for the viability of our society, it often ends up being the most transformative and fulfilling experience in a parent's life. Yet, so much of our societal messaging encourages us to shun that path and put our hearts into other things. In parallel, a general disconnect has been fostered upon this entire process where it is treated as a sterile, lifeless, and mechanistic event we need to be separated from and entrust to someone else—which I believe is the ultimate problem that underlies many of the issues that will be discussed in this article.

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The History of Midwifery

A lot of the dysfunctional things that have come to characterize the birthing process (e.g., unnecessary hospital interventions that create complications begetting more hospital interventions) make much more sense once you understand the history behind them and how childbirth was transformed from a natural human life-event to a medical emergency requiring those interventions.

From the start of America, midwives were highly valued in colonial communities, receiving housing, food, land, and salary for their services (particularly since they also served as nurses, herbalists, and veterinarians). Then, during the 1800s, midwives played a key role in the westward expansion, particularly in the Mormon migration to Utah, but by the early 1900s, a variety of social factors (e.g., economic pressure and societal prejudices) caused midwifery's reputation to decline.

Much of this was due to male doctors (who had initially been averse to delivering babies) displacing midwives. This began in the late 1700s when it became fashionable in Europe to have doctors attend deliveries, after which an influential Harvard professor (and its first profession of obstetrics) convinced his American colleagues to enter, for example in 1820 stating:

> Women seldom forget a practitioner who has conducted them tenderly and safely through parturition they feel a familiarity with him, a confidence and reliance upon him which is of the most essential mutual advantage. . . . It is principally on this account that the practice of midwifery becomes desirable to physicians. **It is this which ensures to them the permanency and security of all their other business.**

Once doctors entered the field of midwifery, it quickly became necessary to justify their "expertise" and a gradual medicalization of childbirth began.

Dr. Joseph DeLee (who later became known as the father of obstetrics), in 1895, opened Chicago's first obstetric clinic, and since it was successful, opened an obstetrics hospital which also trained doctors and nurses and developed lifesaving innovations (e.g., incubators for premature infants) which lowered the childbirth mortality rate.

Simultaneously however, because DeLee observed so many complications and deaths from childbirth, he was of the opinion that natural childbirth was extremely dangerous for both the mother and child, and hence needed to be medicalized. In turn, he spoke actively (e.g., at a 1915 professional meeting) against the use of midwives, arguing they lowered the standards of the profession, and were childbirth to be seen as a more dignified profession, higher fees could be charged, and more doctors would be willing to replace midwives.

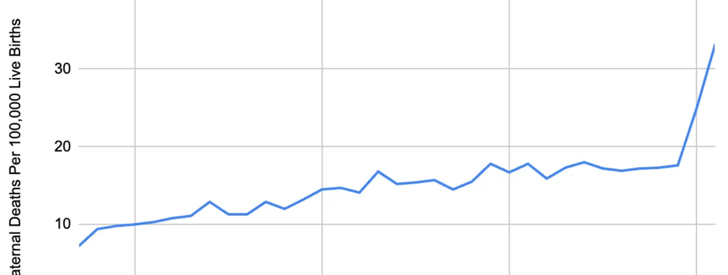
Following this (like many zealots), in 1920, he argued that the approaches he had developed for challenging pregnancies (e.g., forceps, episiotomy, toxic anesthetics) should be used for most of them, while other doctors argued these approaches were too aggressive in many of the situations where DeLee advocated for them. However, due to his growing influence in the profession and success in making childbirth a part of the medical curriculum (in part due to how many doctors he trained) by the 1930s, his standardized invasive approaches became increasingly popular, particularly since society had become enamored with advanced technology improving things.

Finally, near the end of his career (in 1933), due to increasing maternal deaths and complications from hospital infections, he became an advocate for cleaner maternity wards, which met significant resistance from his colleagues (although not as severe as what Ignaz Semmelweis faced almost a century in Austria for pointing out that doctors not disinfection their hands was routinely killing mothers).

From one perspective, I can greatly sympathize with where DeLee came from, as significant issues needed to be addressed (e.g., in 1913, the infant mortality rate was 13.2%). However, he failed to recognize many of them were due to the abhorrent living conditions of the time (which as I show here were also the primary driver behind the incredibly high mortality from infectious diseases).

At the same time however, some of his approaches (e.g., making women partially unconscious during labor and then pulling the babies out with forceps) were abhorrent (and explicitly detailed within his classic 1920 paper), and set the stage for a variety of other harmful and unnecessary interventions to hijack the childbirth process.

Worse still, he seeded the idea within the medical profession that childbirth was inherently pathologic and required a doctor to save the mother and child—despite the fact for most of human history, we had not needed them. Likewise, the maternal death rate was actually the highest between 1900-1930 (when DeLee's practices came into vogue), and it was only after years of deaths and mistakes that the standard of care began being improved and maternal deaths declined. Nonetheless, even now, over a century later, the United States still has a significant issue with these deaths (which is particularly noteworthy as during the period below, those deaths were declining in the other wealthy nations).



Note: another controversial doctor James Marion Sims, who in 1845 began experimental gynecological surgeries on African American slaves (without anesthesia—and operated some on individuals up to 30 times) and after roughly 4 years of work, perfected the surgeries enough to use them on white women (with anesthesia) after which, in the 1850s, he opened the first women's hospital (which was mired in controversy due to how barbaric some of his procedures were, their high fatality rate, and some of the unnecessary brain surgeries he did on black children). Nonetheless, he became one of the most famous doctors in the country (e.g., he was the 1876 president of the AMA) and is considered to be the father of gynecology.

At the exact same time DeLee's work occurred, a variety of federal and state initiatives recognized that the incredibly high infant and maternal mortality rates were connected, and that appropriate prenatal care could prevent them (e.g., Mother's Day was created at this time to provide maternal support to prevent those deaths).

Simultaneously, a debate known as the "Midwife Problem" unfolded, with some (e.g., doctors) advocating for the abolition of midwifery (largely to shield themselves from competition) and others supporting it with proper training and licensing (as they felt midwives could play a critical role in preventing deaths if utilized correctly). Laws were passed in some states (e.g., those that simply did not have enough doctors to attend childbirths) to regulate midwifery, and schools were created to improve midwifery standards. However, by the 1930s, the increased use of hospitals for deliveries made it possible to close many of these schools.

Fortunately, a 1921 Federal law provided for training nurse midwives, and in 1931 (owing to the increasing recognition of the failures of American obstetric care), a successful nurse midwifery school emerged (which amongst other things, had a maternal mortality rate of one-tenth that of the country). Their graduates then created numerous schools and created the modern discipline of nurse midwifery.

Note: in parallel, the Frontier Nursing Service (founded in 1925 by a British trained midwife) trained nurses and provided extensive midwifery (and medical care) to the woefully underserved inhabitants of the Appalachians, which ultimately resulted in a far lower maternal death rate (roughly one third as much as the rest of the country). In turn, when many of its nurses returned to England at the start of World War 2, they also created a successful nurse midwifery program there as well.

Following this, in the 1940s and 1950s, due to limited existing opportunities to practice clinical midwifery, most of the graduates of these programs had to fill other obstetric related roles, and ultimately only a quarter served as midwives. In the 1960s, a variety of attempts were made to address this (e.g., having them work at hospitals where 70% of the births were taking place), and it was not until 1968 that more opportunities began to emerge (due to one school finding a way to integrate with New York's medical system).

Shortly after, a variety of rapid shifts occurred (e.g., key professional organizations endorsed nurse-midwifery, feminism came into vogue, the media promoting midwifery, federal funding for it, an explosion of childbirths from the baby boomers coming of age that the existing system could not accommodate) which propelled midwifery into the mainstream. In turn, many doctors began partnering with midwives, programs became officially recognized by the U.S. Department of Education, and public demand for midwife supervised home births exploded.

This increased demand quickly exceeded the available supply, after which there was a rapid proliferation of non-nurse midwives (lay midwives) with highly variable degrees of training (who had their first national meeting in 1977). By the 1980s, nurse-midwives were present throughout the healthcare system, and a split developed in the medical community between obstetricians who recognized their value and worked with them versus those who viewed them as economic competition that needed to be eliminated (particularly because there was now an overabundance of obstetricians).

Since then, midwifery has faced additional obstacles from the medical system but has continued to develop. Mixed opinions exist within the obstetrics field towards midwifery, and its accessibility varies. Since the 1990s, approximately 1% of births have been at home (although recently it suddenly increased to 1.5%).

Note: this abridged history necessarily omits the immense struggles countless incredibly dedicated midwives went through to make midwifery available to the public or just how much that work approved the abysmal obstetric care that existed throughout the country and the human cost that came with it.

A Standard Hospital Birth

When women go into labor, it is frequently viewed as a medical emergency that necessitates getting to the hospital as quickly as possible (e.g., this idea has been reinforced in television and movies for decades) and then struggling and having the doctor miraculously deliver the baby.

During this whole process, the following will happen.

•The mother will be placed in an uncomfortable and stressful environment (where many unfamiliar people enter and exit the room), be subject to repeated vaginal examinations, and typically placed on her back with the legs spread out.

•The mother will be placed on fetal heart rate monitoring (typically via the abdomen, but sometimes also through an electrode applied intravaginally to the baby's head).

•If the mother delivers too slowly, she will be given pitocin (oxytocin) to speed up the rate of contractions and may have her amniotic membrane prematurely ruptured.

•To mitigate her discomfort, she will often be given an epidural.

•Once the baby starts to come out, it may be pulled out with forceps or a vacuum extractor if the labor progresses "too slowly" or an issue arises.

•To prevent tearing and to make childbirth easier, mothers will often be given a prophylactic episiotomy, which preemptively cuts the vaginal opening to widen it.

•If any of the above goes awry, the mother will be converted to having a C-section.

•Once the baby is born, the cord will be immediately cut (and the placenta disposed of). The baby will typically be separated from the mother for a prolonged period (e.g., to go to a newborn nursery or the neonatal intensive care unit), and will receive a vitamin K shot and a hepatitis B vaccine and then have their blood drawn. Lastly, if the baby is a boy, circumcisions are often performed in the first days of life while they are still at the hospital.

•Finally, following this, if all goes well, the mother will go home with the baby in a few days, or a week if issues emerge.

However, while many of these steps can potentially save an infant's life, many of them create significant long-term complications, and many increase the likelihood more hospital interventions will be needed.

This in turn, touches upon a criticism of the medical industry—medical interventions often thrust you onto an assembly line that requires more and more of them (e.g., many psychiatric drugs are prescribed to treat the side effects of other psychiatric drugs). Typically, it takes time to see this process play out, but in the case of labor and delivery, the changes requiring additional interventions occur quite rapidly—whereas in contrast, almost none of this is seen outside of the hospital.

Note: I believe this bias towards excessive intervention in part occurs from obstetric units being understaffed (e.g., if a doctor is attending 6-10 mothers, the deliveries need to be artificially sequenced so that they don't occur simultaneously and accelerated so they aren't held up in one place) and due to OBYGN's having significant liability risk if anything goes awry with a pregnancy if the standard protocols had not been followed.

> Any intervention that interferes with women's ability to cope in labor has enormous implications: it can destroy feelings of achievement and self-esteem. Women who feel they have coped have more confidence in their mothering abilities than women who feel traumatized by the birth process. Specifically disturbing to this aspect of common labor ward practice is the data of Robson and Kumar reporting an association between procedures in labor, such as artificial rupture of the membranes, and the delayed onset of maternal affection.

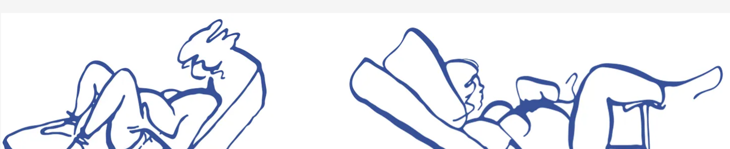
We'll now look at the issues with each of the previous approaches.

*Note: as we go through these, consider that America currently spends at least 111 billion dollars on childbirth (which is twice that of most high income countries) yet **ranks last** amongst the high income nations in both infant and maternal mortality.*

Birthing position

There are many different positions where a mother could give birth.

However, in most hospital births, mothers deliver on their backs with their knees up (e.g., a 2014 study of 2,400 hospital births found 68% gave birth lying on their backs, and 23% did so lying down while having their backs propped up).



These images are from a short article on birthing positions and the risks of lying down.

Note: The primary reason these positions are used as hospitals is that they make it much easier to manage hospital deliveries and main healthcare providers to conduct them (looking at them not being comfortable with any other positions). Many also believe they serve to enforce a power dynamic where modern medicine is in control of the process, and by extension, to participant as well.

Despite this being the norm, and despite most healthcare workers knowing it is not the ideal position, it is quite controversial as:

•Lying down closes the pelvis making it harder to push the baby out. In contrast, squatting allows the force of gravity to help the baby come out and has repeatedly been shown via MRIs to increase the size of the pelvic outlet that the baby has to exit.

•Compressing the vacuum by lying down or sitting/ dramatically reduces the ability of the coccyx (or public symphysis) to move and accommodate the baby passing through.

•Different labor positions are often much more comfortable than lying on the back. For example, a study of 2992 home births (where mothers are allowed to choose their birthing position) found only 8% of mothers chose to deliver lying down (along with 23% who do so lying down with their backs propped up).

•Lying on the back can compress the mother's vena cava and thus the blood supply to the fetus.

In turn, a 2017 Cochrane review found that delivering while standing decreased abnormal fetal heart rates, accelerated labor, and reduced the need for assisted births (e.g., forceps deliveries) or episiotomies. A later 2020 review found those same benefits to a greater degree (e.g., there was a considerable reduction in perineal tears).

Note: in many ways, this situation is analogous to the defecation (pooping) position we use, as when you sit in the normal position we use on the toilet, it partially closes down the rectum (hence making it much harder to poop), whereas if you squat, it's much easier for the process to occur naturally. However, despite this making a huge difference for bowel health, virtually no one knows about it, and our toilets are highly counterproductive to having healthy bowel movements (all of which are discussed further in this article, about the forgotten natural ways to treat constipation).

Fetal Heart Rate Monitoring

An infant's heart rate can indicate if they are in danger (e.g., because their blood supply is being partially cut off), and can be assessed either with a specialized stethoscope or continuous ultrasound (which is what is typically done). Fetal heart rate monitoring forms a cornerstone of obstetric practices. It is almost always done in the hospital (which also incentivizes having the patient lie down as it's much harder to monitor in more natural birth positions).

However, while abnormal heart rates correlate to a variety of potential issues, extensive studies (e.g., consider this 2006 Cochrane review) have consistently found that when compared to periodic stethoscope examinations, fetal heart rate monitoring does not reduce death or disability but does increase the likelihood of a C-section by 66% and an instrumental birth by 16% (due to the abnormal heart rates making doctors want to save "at risk" babies).

Pitocin

Oxytocin is the hormone that stimulates uterine contractions. Because of this, synthetic oxytocin (pitocin) will often be given to induce labor or accelerate a delayed labor. Pitocin can be quite helpful, but unfortunately, it is frequently given at far too high of a dose (e.g., because a natural labor peak is deemed "too slow"). This leads to a few common issues:

•Pitocin can induce contractions before the cervix is ready to open leading to the baby being pushed along but not able to get out, leading to prolonged labor that can require C-sections.

•Pitocin causes much stronger (and frequent) contractions, which are often quite painful (hence leading to increased pain for laboring mothers and a need for pain-relieving medications).

•Excessive uterine contractions can compress and interrupt the blood supply to the fetus, leading to abnormal heart rates and possibly C-sections.

•The perineum needs time to stretch during labor before the baby comes out, so pushing the baby out too quickly can cause it to tear (similarly, one study found pitocin makes anal sphincter tears during labor 80% more likely, while another found induced labors were twice as likely to have perineal lacerations).

Note: occasionally, the excessive contractions can also be too much for the uterus and rupture it.

•Excessive contractions increase the risk of maternal bleeding (e.g., one study found pitocin induced labors were 6% more likely to cause postpartum hemorrhages and increased total postpartum bleeding by 46%).

Because of the previous complications, excessive oxytocin can significantly increase the likelihood of C-sections (e.g., one study found that higher doses of oxytocin made women 40% more likely to need C-sections).

Note: common side effects of pitocin include nausea, stomach pain, vomiting, headache, and fever or flushing (while a more extensive list with the more severe reactions can be read on the FDA label).

Artificial Rupture of Membranes

Another procedure used to induce labor and accelerate prolonged labors is to rupture the amniotic sac (so the water breaks) despite the evidence showing amniotomies do not significantly accelerate labor. Conversely it:

•Increases the pain of labor (e.g., a 1989 study of 3000 women found two-thirds of them felt it increased its rate, strength, and pain of contractions and made them more challenging to deal with).

•Can cause the umbilical cord to drop before the baby (e.g., one study found it happened in 0.5% of amniotomies, which cuts off the fetal oxygen supply is).

•Increases the risk of infections (as the amniotic membranes protect the fetus from microorganisms).

•Increases the risk of C-sections.

Sadly, amniotomies are frequently done (e.g., in 40.6% of deliveries in Sweden), despite medical guidelines advising against them for routine deliveries.

Note: another long standing problem with amniotomies is that doctors in certain areas will not discuss the procedure with women before it is performed.

Episiotomies

Episiotomies (surgically cutting the back of the vaginal opening and part of the perineum, then sewing it back together after delivery) used to be performed in the shadows of a doctor (as the stitches attached to the top of it. This practice has gradually become less frequent (it is now only 5% of American births) due to increasing awareness about its harms and C-sections being done instead. Unfortunately, much of the world still has not reconsidered this.

Note: the most severe complication I've come across from an assisted delivery was a baby with a challenging birth recently being diagnosed due to too much force being used to pull the baby out.

Additionally, due to how malleable the skull is at birth (as the cranium has not yet fully formed), vacuum pumps and forceps can significantly distort the shape of the bones. While these changes are typically not considered concerning within the conventional medical field, many holistic schools of medicine place heavy emphasis on them, and we have met many adults who still had detectable dents from the forceps in their skull (along with many others who had decades of headaches).

Note: within these fields, vacuum pump deliveries are typically considered to be more problematic for the skull.

Skin to Skin Contact

At this point, I am relatively certain babies are supposed to go on their mother's skin after birth, as this is immediately healing for both of them, and in many cases can stabilize abnormal vital signs and sometimes save at risk babies (e.g., in less affluent countries, it's been shown to reduce mortality of low birth weight infants by 25% and I've seen quite a few miraculous instances of it stabilizing a baby).

Unfortunately, since everything in medicine is about streamlining the procedure and getting things done as quickly as possible, years of work went into pressuring hospitals to support this, and even now it's not universal. Because of this, it's important to verify you have this option and to push for it (including if your infant was delivered via a C-section unless there is an urgent reason not to do so. Additionally, you should make a point to have skin-to-skin contact after childbirth.

Note: many of the benefits of skin-to-skin contact are ascribed to it educate oxytocin, the bonding hormone that creates contentment, trust, empathy, calmness, and security while reducing fear and anxiety and also moving milk through the breast ducts. While this is true, I also believe there is a vital energetic exchange that occurs (which is arguably more important).

For context, benefits of immediate (and daily) skin-to-skin contact for the infant include:

•Shortening the time until a premature infant can be fed orally.

•Preventing low blood sugar in infants and NICU admissions for it (e.g., a 50% reduction).

•Improving the gut microbiome.

•Less crying and improved sleeping durations (which as any mother can attest is very important).

•Developing the emotional capacities of the brain (e.g., increasing empathy later in life).

•Improved behavior, social interactions, and cognitive function in early childhood.

•Reduced physiologic response to stressors in infants and improved maternal bonding.

•Enhanced cognitive development

While for the mother they include:

•Reduced maternal PTSD (and other negative emotions) following childbirth (e.g., feelings of fear and guilt in mothers who had C-sections).

•Decreasing maternal anxiety and fatigue.

•Increasing breastfeeding success (improving the likelihood, and duration of breastfeeding (e.g., by 24%), including after C-sections.

Note: many of these benefits have also been observed in fathers who have skin-to-skin contact with the infant (e.g., improved vital signs, crying, and feeding in infants, along with reduced anxiety and depression in the father).

Umbilical Cord Clamping

Typically, when a baby is born, the umbilical cord will be quickly clamped, and then (if around) the father will be given scissors to cut it so he can feel like he's part of the process, after which the placenta will be extracted and thrown away. The problem with doing this is that the blood inside the placenta (and the placenta tissue itself) is one of the most healing substances in nature, so it contains a large number of stem cells and vital growth factors.

This makes it vital for the baby to recover from the trauma of the birthing process; likewise, the placenta provides a critical source of nutrition for the mother.

Note: many hospitals will not allow you to preserve the placenta for encapsulation and consumption, while others may, provided you follow a set of procedures. As such, if you wish to do that (which I advise), it must be figured out before delivery.

Additionally, these materials provide the most ethical (and potent) source of regenerative medicine products available (e.g., cord blood stem cells, if used correctly, are often a miraculous therapy. A variety of very potent regenerative therapies can be made from the placenta, and the amniotic fluid provides an excellent source of exosomes).

Note: one of the many harmful things Biden did early in his presidency was having the FDA effectively outlaw umbilical cord blood stem cells (which largely killed the industry) and vaccinate mothers across America (so this has been shown to significantly impair the quality of their cord blood stem cells). Fortunately, shortly before the election, RFK announced he would end the FDA's prohibition on them.

In turn, various benefits have been identified from delayed cord clamping, particularly in premature babies (the most vulnerable to losing this essential blood). These include:

•Increasing the blood volume (by up to a third) and the body's iron stores (which is critical for brain development in the first few months of life) along with decreasing the need for infants to receive transfusions (e.g., 10% less likely in one study).

•Improving cardiovascular stability (e.g., blood pressure), and organ function (as more blood is available).

•Improved respiratory function (as the lungs depend upon blood coming in and out of them, which reduces respiratory distress (particularly severe extended placenta blood flow aids the transition from umbilical to pulmonary circulation).

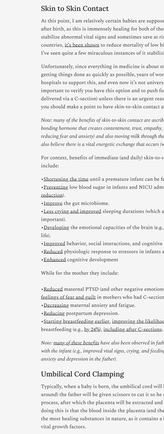
•Reduced intraventricular hemorrhages (brain bleeds) since the cord blood stem cells repair wounds (e.g., this study found a 60% reduction, while this study found a complete elimination of them (and seizures).

•Reduced necrotizing enterocolitis (e.g., this study found a 41% reduction), a severe condition (27% mortality) that affects 3-5% of premature infants each year.

•Improved brain myelination, and neurological development.

Note: for most of history, cords were not clamped (it began in the 1600s), in the 1700s it was critiqued and by 1801, authors were warning that rapid clamping discussed an infant's health and vitality. Starting in the 1950s, research and practice opinions started changing arguing against rapid clamping. Still, it was not until the 21st century that guidelines began advocating for slightly delayed when cords were clamped (e.g., in 2008 the WHO did, then in 2017 ACOG did for preterm infants, and in 2016 ACOG did for all infants). Despite this, only approximately 30% of US hospital births receive DCC (with the highest rates seen in hospitals that deliver fewer babies—presumably because they are more cautious), and a 2019 global survey found most doctors either only occasionally practiced DCC or never did so.

In short, a good case can be made that many of the birthing complications we see arise from prematurely clamping the umbilical cord. As such, it's unconscionable that the medical field has been so resistant to delaying cord clamping. Over the years, a variety of rationalizations have been provided by the medical field for why this procedure should be done, but in my eyes, it's ultimately due to the fact there are too few healthcare workers in birthing units, so any step that can be reached (e.g., saving a few minutes by clamping a cord) will be skipped—even when a small action can provide a profound benefit for the baby.



When forceps are used, roughly a quarter of mothers experience injuries such as vaginal tears and sphincter injuries, while more severe complications (e.g., 3rd or 4th degree vaginal tears, are reported in about 8 to 12% of those undergoing forceps delivery. Likewise, when vacuum cups are used, 20.9% experience vaginal tears, and 2.4% experience postpartum hemorrhages.

Note: another study found 13.2% of mothers experience complications from vacuum cups.

When forceps or vacuum pumps are used for infants, a variety of injuries can occur, with severe traumas (e.g., injuries to the nerves for the arms, skull fractures, or brain injuries and bleeds) estimated to occur in 2.96% of births. A variety of other less severe injuries (detailed here) also occur such as bruises, lacerations, hematomas, and neonatal jaundice (which occurs in 14.5% of assisted deliveries).

Note: within these fields, vacuum pump deliveries are typically considered to be more problematic for the skull.

Forceps and Vacuum Cups

Frequently, if a delivery is progressing too slowly (or the fetus is deemed to be at risk) the infant will be pulled out by the head, either with clamps that grip each side of the skull or a suction cup that attaches to the top of it. This practice has gradually become less frequent (it now only 5% of American births) due to increasing awareness about its harms and C-sections being done instead. Unfortunately, much of the world still has not reconsidered this.

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Sleep Deprivation

Sleep deprivation is a very potent source of mentally ill behaviors (e.g., but it also weakens immune function, increases inflammation, and increases the risk of cancer, heart disease, and diabetes). Unfortunately, it is very common for new parents, and it's often made worse by the fact that many hospitals will not allow you to preserve the placenta for encapsulation and consumption, while others may, provided you follow a set of procedures. As such, if you wish to do that (which I advise), it must be figured out before delivery.

Additionally, these materials provide the most ethical (and potent) source of regenerative medicine products available (e.g., cord blood stem cells, if used correctly, are often a miraculous therapy. A variety of very potent regenerative therapies can be made from the placenta, and the amniotic fluid provides an excellent source of exosomes).

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•Improved respiratory function (as the lungs depend upon blood coming in and out of them, which reduces respiratory distress (particularly severe extended placenta blood flow aids the transition from umbilical to pulmonary circulation).

•Reduced intraventricular hemorrhages (brain bleeds) since the cord blood stem cells repair wounds (e.g., this study found a 60% reduction, while this study found a complete elimination of them (and seizures).

•Reduced necrotizing enterocolitis (e.g., this study found a 41% reduction), a severe condition (27% mortality) that affects 3-5% of premature infants each year.

•Improved brain myelination, and neurological development.

Note: for most of history, cords were not clamped (it began in the 1600s), in the 1700s it was critiqued and by 1801, authors were warning that rapid clamping discussed an infant's health and vitality. Starting in the 1950s, research and practice opinions started changing arguing against rapid clamping. Still, it was not until the 21st century that guidelines began advocating for slightly delayed when cords were clamped (e.g., in 2008 the WHO did, then in 2017 ACOG did for preterm infants, and in 2016 ACOG did for all infants). Despite this, only approximately 30% of US hospital births receive DCC (with the highest rates seen in hospitals that deliver fewer babies—presumably because they are more cautious), and a 2019 global survey found most doctors either only occasionally practiced DCC or never did so.

In short, a good case can be made that many of the birthing complications we see arise from prematurely clamping the umbilical cord. As such, it's unconscionable that the medical field has been so resistant to delaying cord clamping. Over the years, a variety of rationalizations have been provided by the medical field for why this procedure should be done, but in my eyes, it's ultimately due to the fact there are too few healthcare workers in birthing units, so any step that can be reached (e.g., saving a few minutes by clamping a cord) will be skipped—even when a small action can provide a profound benefit for the baby.

Note: ideally, you should not clamp the cord until it stops pulsating (arguably, you should wait even longer because some cord blood still transfers into the baby afterward). In many cases, this takes much longer than the minute hospitals allocate for delayed cord clamping.

Injections

After childbirth, infants are immediately given a vitamin K shot (within 6 hours) and a hepatitis B vaccine (within 24 hours), and the pressure to do these is so strong that if they are declined at a hospital, it can result in a child protective services referral.

In the case of the hepatitis B vaccine, there really isn't a reasonable justification for it as you can only get hepatitis B through sharing drug needles or sex, and the vaccine typically lasts for 5 years. In contrast, it exposes children to significant potential harm, particularly since its antigen mimics prolin and hence has the potential to cause autoimmunity illness in developing brain tissue.

Note: the two answers I've heard over the years from insiders for why it's actually given then is either to habituate parents to bringing in their babies for pediatric vaccine appointments or so that the vaccine can be on the infant schedule and hence enjoy the liability protections afforded by the 1986 vaccine injury act.

In the case of vitamin K shots, the argument for them is that infants are often deficient in vitamin K (which is necessary for blood clotting) as it does not transfer through the placenta and instead must be obtained through breast milk. As such, without supplemental vitamin K, they are more likely to experience subcutaneous bleeding, which, without prevention, in the first 24 hours affects between 0.25% - 1.7% of infants and 1-2% of infants between 2-10 weeks of age (of whom, assuming the estimates are not biased, 20% die). Furthermore, while oral vitamin K can also prevent this, the effect is not as long lasting (it needs to be done multiple times), so a shot is considered a more effective way to ensure it does not happen (e.g., if the parent does not give subsequent oral doses).

In contrast, there is evidence suggesting that vitamin K injections create chronic health issues, so a subset of parents decline taking it (which in turn leads to a small number of infant bleeding events)—many of which could likely be prevented if safer shots were based on the additives rather than vitamin K are the most likely issue). Furthermore, while I cannot prove this, I believe the actual issue is early cord clamping, and if proper delayed cord clamping were widely practiced, much of that bleeding would not occur.

Note: there is a surprising lack of data in this area, but from looking at all of it, my best is that the vitamin K shots prevent approximately 1 in 1000 children from dying. Conversely, 0.2 in 1000 children experience a severe reaction to the shot.

Lastly, there is quite a bit of evidence demonstrating that premature infants (gathered from NICU data) are more susceptible to sudden infant death syndrome following vaccinations (particularly if multiple vaccines are given concurrently).

Note: there is also a bit of data that giving a mother antibiotics during can adversely affect the infant later in life (e.g., it has been linked to obesity, epilepsy, cerebral palsy, and asthma).

Cesarean Sections

C-sections bypass the birthing process by cutting open the abdomen and directly extracting the baby. While they are sometimes necessary (e.g., the WHO made a good case that in 10% of births, they prevent maternal and infant mortality), they are done far too frequently (e.g., in 2019, 32.2% of all births were C-sections).

Note: one of my least favorite statistics in medicine is that C-section rates dramatically rise at the times doctors typically want to go home.[1,2,3]

Surgical Risks

Being a surgery, C-sections carry a variety of issues commonly seen with other surgeries like the mother needing a 4-6 week recovery period (which longer than that from a vaginal birth), a global 5.45% infection rate (which is a bit lower in the United States), and significant pain (is not the most important healing period of your life), potential reactions to general anesthesia and accidental organ injuries (particularly since some c-sections need to be done very quickly to save the baby's life).

Additionally, there are some surgical complications more unique to C-sections such as:

•Damage to the lining of the uterus creating adhesions and scars which cause the placenta to attach in the wrong place in future pregnancies (e.g. two C-sections make women 124 times more likely to have a placenta accreta).

•The weakened uterine scar can rupture during a subsequent delivery (especially if oxytocin is used), so one C-section can result in patients needing to have all subsequent births to be C-sections as well (particularly if the placental attachment becomes abnormal).

•The infant can accidentally get cut during the C-section (e.g., 1.5-3.9% get facial lacerations).

•The scars often cause significant issues for women for years if not decades (until they are correctly treated)—which in many cases they do not realize are the root cause of many of their issues until you point it out.

•The general anesthetics used for the C-section can increase an infant's risk of neonatal complications.

Note: C-sections also cause a variety of other issues, such as breastfeeding problems, worsened sleep, and emotional challenges (e.g., PTSD or anxiety).

However, beyond the surgery itself, simply bypassing the normal birthing process can also cause significant issues for infants.

Acute Risks

Hyaline membrane disease (respiratory distress syndrome—RDS) affects approximately 20,000 infants in the United States annually and is the leading cause of neonatal fatalities. The birthing process protects against this (e.g., studies have found premature C-section babies are 2.4-5.92 times more likely to have RDS[5,6]). Likely due to its mechanical pressure forcing excessive fluids out of the lungs.

Note: in 1979, Dr. Robert J. Mendelsohn (one of the trailblazing medical dissidents) discussed a recent study that concluded 6,000 of the 40,000 cases of RDS could be prevented by not bringing babies out of the womb before they were ready and then stated, "Yet the rates of induced deliveries and Cesarean sections are going up, not down. I can remember when a hospital's incidence of Cesarean deliveries went above four or five percent, there was a full scale investigation. The present level is around twenty-five percent. There are no investigations at all. And in some hospitals the rate is pushing fifty percent."

Chronic Risks

C-sections have also been linked to a variety of chronic issues, most of which are immunological in nature. For example:

•A Kaiser study of 8,953 children found C-sections increased allergic rhinoconjunctivitis (hay fever) by 32%, asthma by 24% (5.8% vs. and 4.8% in boys).

•Roughly 2000 studies have assessed the link between C-sections and asthma. From them, a 2020 meta-analysis found C-sections increase asthma by 41%, while a 2019 meta-analysis found a 20% increase.

•A Danish study of 750,000 children aged 0-14 assessed a few autoimmune diseases and found those born by C-sections were roughly 20% more likely to develop Laryngitis, Asthma, Gastroenteritis, Ulcerative colitis, Celiac disease, and Juvenile Arthritis (along with Pneumonia and other lower respiratory tract infections).

•A larger Danish Study of 2,099,439 births found that elective C-sections caused a 14% increase in diabetes, a 14% increase in rheumatoid arthritis, a 4% increase in Crohn's disease, and a 15% increase in irritable bowel disease. Generally, the risk for these conditions was higher in women and for elective C-sections (with the exception of Chron's increasing by 15% after emergency C-sections). Another similar study also found C-sections significantly increased the risk of asthma, systemic connective tissue disorders, juvenile arthritis, inflammatory bowel disease, immune deficiencies, and leukemia.

•A study of 1,174,787 births found C-sections made infants (in the first 5 years of life) 10% more likely to be hospitalized for infections (particularly respiratory, gastrointestinal, and viral ones).

•A study of 33,326 adult women found being born by C-section made them 11% more likely to be obese and 46% more likely to develop type 2 diabetes.

Much of this is likely due to C-sections disrupting the microbiome (which can persist into adulthood) as infants deprived upon the vaginal flora (and external fecal flora) to initially colonize the gastrointestinal tract (as the microflora of the vagina are predominantly composed of the "good bacteria" our digestion needs and shortly after birth, the stomach starts producing stomach acid so other bacteria can't as easily colonize the GI tract). In turn, many studies have found C-sections significantly disrupt the microbiome, including a prospective trial that determined that the degree of lasting microbiome disruption in an infant directly correlated to their likelihood of developing asthma and allergic sensitivity.

Note: one partial solution to this which does not address hurtful hospital microbes displacing the normal microbiome is to inoculate the infant with the mother's vaginal secretions immediately after delivery. However, while complaints have emerged for vaginal seeding in the last decade (e.g., this page and this page), it is not currently endorsed by the medical community, and most hospitals do not offer it.

Neurological Issues

Finally, C-sections have been linked to a variety of neurological issues:

•A mouse trial found C-sections led to behavioral changes and increased cell death in certain portions of the brain, while a retrospective MRI study of 966 children found that C-sections significantly reduced brain white matter and functional neural connectivity. A larger 2017 study (published in nature) found that C-section children (ages 6-9) performed lower on standardized tests than vaginally born children and that this was not due to confounding variables, while a 1978 Swaiman study found C-sections caused lower motor and language development scores during specific age windows in the first three years of life.

A 2020 Canada study found 3 year old children born via C-section had poorer performance on cognitive tests than children born via vaginal delivery.

•C-sections have been found to increase the rate of ADHD by 15-16% and autism by 23-26%, while early onset schizophrenia has also been associated with C-sections (much of which may be due to C-sections clustering the dopamine receptors in the brain).

Note: as this study shows, the increase in autism is strongly correlated to mothers receiving general anesthesia during the C-section.

•C-sections have been found to impair a newborn's ability to recognize familiar scents, make them more averse to being touched or hugged, and have poorer sensory integration, visual memory, and visuospatial perception. In parallel, mothers of C-section babies have been found to have less attachment to and more negative evaluation of their children.

Since neurological development is such a complicated process, it's difficult to say which factor (e.g., anesthesia, reduced maternal bonding, gut microbiome alternations) is ultimately responsible for these changes. However, many excellent healers I've talked to from a variety of traditions (e.g., the New Zealand Maoris) have shared that they noticed there is a loss of vibrancy and vitality in C-section babies which they attribute to them not "getting a spark" the vaginal birthing process facilitates (e.g., because the micro-motion within the skull is catalysed by the compression experienced during the birthing process).

One of the most interesting conversations I had on this subject was with a doctor who shared that he was taught the vitality of infants directly correlated to how much they cried at birth (which is why, in the older days doctors would stack baby sides to trigger a vigorous cry). In turn, when he and his colleagues attempted to help struggling infants with birth trauma by gently compressing the tops of their skulls to recreate part of the birthing process, they found that C-section infants would be not a brief but very vigorous cry, whereas children who had been born vaginally typically had a much softer cry—something they attributed to the initial birthing process not having catalysed the cry they needed then (which is why it was so loud at the subsequent compression).

Note: this is somewhat similar to the observation in homeopathy that patients who can mount fevers tend to have stronger vitalities and better responses to homeopathic remedies, but as the decades have gone by, people have become less able to mount fevers and have more sluggish responses to homeopathic remedies.

High Risk Births

One of the major factors in deciding what to do for a pregnancy is if you have a "high-risk" pregnancy. As I discussed in a previous article on prenatal ultrasounds (which abundant data shows are not safe and hence must be used quite cautiously), determining what constitutes a "high-risk" pregnancy is quite subjective, and that designation being erroneously applied frequently results in a lot of stressful, unnecessary and potentially harmful interventions.

Note: we believe the most appropriate use of ultrasound is a very brief low-dose evaluation at the 20-22 weeks (or when the mother goes into labor) to determine the position of the placenta and baby, whereas for most other routine uses (where there are signs of an issue such as unexpected bleeding, the risk of ultrasound outweighs its benefits (and typically there is an alternative option that can safely get the needed information).

Typically, there are a few common situations that can require hospital births:

•The placenta is in the wrong place. This typically requires C-sections. However, in many cases, the placenta can move to the correct position, so if this is diagnosed early in pregnancy with ultrasound, it can lead to a lot of unnecessary stress.

•The baby faces the wrong direction with the pelvis instead of the head coming out first (a breech presentation). This is a fairly controversial area as many people I know will deliver breech babies (and it went well), but many others will not (as they have seen bad outcomes or infant deaths) following them (e.g., one large study found breech babies are 2.4 times as likely to die from vaginal delivery). Generally, I believe the best option is to fix the issue before delivery by moving the baby into the correct position which frequently works—provided it is done correctly.

*Note: if one of the infant's legs or shoulders is sticking forward, a vaginal birth **should not be attempted**.*

•The baby is head down, but facing the wrong direction (too facing forward). In our experience, these often end up requiring C-sections as it's not possible to get the infant out.

•Twins are present. This does not necessarily require a C-section, but a variety of issues are more likely to come up, so it can be very helpful to have additional assistance nearby if needed.

•The mother already had a C-section.

•There are other characteristics of a high-risk pregnancy (e.g., the mother is older or obese, there is a concurrent maternal illness, the mother had preeclampsia during the pregnancy).

The Risks and Benefits of a Hospital Birth

Note: in America, a hospital vaginal birth is typically $10,000- $15,000 ($2,500-$5,000 with insurance), a C-Section is $15,000-$20,000 ($3,000-$7,500 with insurance)—although sometimes C-sections with complications can exceed $70,000 and a home birth (including the Midwife's care through the pregnancy) is typically $1,500 to $5,000 which insurance sometimes covers part of. Many in turn, believe this pricing (and the fact the most cost-effective option, doulas, are never paid for) has created a business of being born that does not prioritize the mother and child.

Based on everything that's been presented thus far (along with the more subtle implications of these posters), a strong case exists for embracing a hospital birth entirely, as there are so many risks, particularly if you have a low-risk pregnancy. Conversely, our experience has been that a bit more than 5% of low-risk births ultimately end up needing a hospital birth (which can be quite stressful if you have to suddenly be transferred to the ER and be delivered by the obstetrician who is on-call).

Because of this, there is no correct way to approach this situation, and I feel a lot of that is ultimately due to how incredibly resistant the medical field has been to basic adopting approaches that take a little bit more time but greatly benefit the mother and child. For example, in 1991, the WHO created the "baby friendly hospital" concept (which incorporated a few of the basic things that should always be done), but three decades later, only 30% of American babies were born at hospitals with that designation.

As such, I believe the following are critical to do if you pursue a hospital birth:

•Be familiar ahead of time with what the entire birthing process entails and the choices you will have to make, as it is often incredibly difficult to figure all of that out in the middle of a delivery (which is essentially why I venue this article).

•Strongly consider working with a doula (someone who helps with the childbirth process and afterward but does not have formal training), as the right doula can be immensely helpful. For instance, a Cochrane review showed doulas (or other sources of continual support) are associated with an 8% higher chance of spontaneous vaginal birth, a 25% lower chance of C-sections (also shown in this clinical trial), and a 10% lower chance of instrumental vaginal birth. Labors were also 41 minutes shorter, and women were 31% less likely to have negative childbirth experiences and 7% less likely to use epidurals. Additionally, there was less postpartum depression, and babies had a 38% lower chance of a low five-minute Apgar score. Likewise, this study found doulas decreased epidural use by 11.7%, and made women more likely to have a positive birth experience, feeling in control, as a woman, and body perception.

Note: this study found training a woman's friend for two hours on being a doula provided many of the same benefits as actual doula did—illustrating both the vital need for support and how much room there is to improve this.

•It is extremely important to have advocates with you who do not stress you out, understand what you want during the delivery, and want to support you. This can include the father (dad but really not always possible), a close friend (may cause fear for the role (and are comfortable with having there), or an outside doula or midwife you brought into the facility with you (which can often be extremely helpful). Giving birth can be one of the most empowering and profound moments of your life, but it can also be incredibly painful and challenging, so whoever is with you needs to get that and be supportive rather than an added source of stress.

•Consider making many of the decisions outlined throughout this article (e.g., delayed cord clamping), and if possible, find the best hospital in the area, and identify an obstetrician who you feel comfortable with and who appears open to a more natural childbirth.

Conversely, if you choose to not give birth at a hospital, you need to:

•Make sure you are smart about it and do not endanger anyone.

•Find the right midwife (and doula) to work with. Midwife experience, skill, and how comfortable you will feel with each one varies greatly, so taking a bit of effort upfront to find the right person can pay a lot of dividends (e.g., do multiple interviews or go to an event where you can meet multiple potential candidates to see who you have a resonance with). Larger areas will often have a midwifery community, so by connecting with them, you can get a lot of helpful guidance in this regard.

•Understand the difference between lay midwifery (less training) and a nurse midwife (more training). Generally speaking, nurses who are also trained to be midwives will have more experience with complications and when to transfer to a hospital (e.g., if the baby is in the wrong position, if the baby is too big, if the baby is too far into the birthing process, if the baby is too premature, if there are signs of fetal distress, if there is excessive bleeding, if there are signs of infection, if there are signs of pre-eclampsia, if there are signs of a prolapsed cord, if there are signs of a placenta abruption, if there are signs of a placenta previa, if there are signs of a uterine rupture, if there are signs of a shoulder dystocia, if there are signs of a breech baby, if there are signs of a multiple pregnancy, if there are signs of a C-section, if there are signs of a vaginal tear, if there are signs of a hemorrhage, if there are signs of a stillbirth, if there are signs of a maternal illness, if there are signs of a maternal death, if there are signs of a neonatal illness, if there are signs of a neonatal death, if there are signs of a neonatal seizure, if there are signs of a neonatal hypoxia, if there are signs of a neonatal jaundice, if there are signs of a neonatal infection, if there are signs of a neonatal fever, if there are signs of a neonatal hypothermia, if there are signs of a neonatal hypoglycemia, if there are signs of a neonatal hypotonia, if there are signs of a neonatal hypertonia, if there are signs of a neonatal hypertonia, if there are signs of a neonatal hypert

provide better care and are much less likely to cause disasters, but at the same time, I have mixed feelings about them.

•Make sure you have a good spot to give birth in (which a midwife can help you with).

•Have a plan in place in case you do need to go to a hospital.

•Finally, be sure you are already engaged in a robust pre-natal and pregnancy health plan (as often dramatic pregnancy labor and the longevity of the infant).

Note: from having reviewed the evidence, I can't say with certainty if hospital births have any mortality benefit for low-risk pregnancies. However, in high-risk pregnancies, they do reduce an infant's chance of dying.

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Optimizing Childbirth

As I've tried to show in this article, there are immense issues with how the medical system (still) handles childbirth. In turn, it is my hope a key component of Making America Healthy Again MAHA will be fixing them, as the unique moment we are in has the potential to change many long-standing issues in the medical system, such as those maternal activists have fought for decades to address (or finding ways to reduce the pressure on hospital staff so mothers can give birth in a more natural and related manner).

Since this topic is incredibly important to me, I have spent years upon years searching for better ways to address many issues and dilemmas with childbirth. I have found some very helpful solutions that are still relatively unknown.

These will be reviewed in the final part of the article and include:

•What I now believe to be the best model for where to give birth

•How to mitigate many of the complications from C-sections and vaginal births (e.g., such as vaginal tears and hemorrhages, C-section scars, or an inability for the infant to breastfeed)

•Safe and effective anesthetic options for childbirth.

•The best options for cord blood banking vs. delayed cord clamping and placenta encapsulation.

•What you can do before and during pregnancy to ensure the optimal health of your child (e.g., how to prevent miscarriages and methods for correcting a breech baby) and counteract issues that come up during it (e.g., back pain, preeclampsia, and edema).

•A few other resources I've found to be very helpful for parents wanting to understand and navigate this challenging dynamic.

Note: I would greatly appreciate your thoughts on these approaches as many are still fairly unknown.

Birthing Centers

Birthing centers are facilities typically run by midwives that provide support throughout the pregnancy and a home-like environment for giving birth (and frequently have helpful things like the option for water births. I and colleagues who have run them believe that when birthing centers are set up correctly, they provide the best balance between the risks and benefits of a hospital and a home birth. Doing this requires:

•Having the facility that's very close to a hospital partner with an open-minded obstetrician who works at the hospital, knows the staff at the birthing center, and sees each mother who goes to the birthing center his he can be aware of their situation and be sure they have a low-risk pregnancy).

•Have the obstetrician provide strict criteria for the midwives to follow, which protect everyone and include which events (e.g., an early rupture of the amniotic membrane or an abnormal placenta) require the birth to occur at the hospital instead.

Most mothers can have a peaceful and supported delivery if this is done. However, for the 5-10% who either do not (and need more care) or meet the OBGYN's criteria for a hospital birth, they can then be transferred to the hospital and work with someone who is expecting them and knows what they want. This in turn, is extremely important as one of the worst things a mother in labor can experience is being thrown into the ER, not knowing anyone there, and being rushed into a hospital delivery by staff who are likely judging her for the whole thing and are less likely to be able to respect her wishes for how the birth should be conducted.

Note: getting an adjustment of the pelvis before giving birth can help make labor easier, as if anyone in the midwife community knows a good person in the area, it's worth using them as the off chance a bone is out of place and obstructing the infant's path out of the pelvis.

Safe Pregnancy Anesthesia

One of the major issues with childbirth is that all of the painkillers and anesthetics used expose the fetus and sometimes the mother to significant risk. As such, it is remarkable that one medication GDHI was discovered that was both an effective painkiller and anesthetic depending on the dose; but also was completely safe and actually called childbirth. To cause a 19th review paper in was being used in France and Italy at the time:

> Recent observations would indicate that this drug can be very useful in delivery. Independently of the decrease in anxiety and consciousness obtained, it showed an **absolutely spectacular action on the dilation of the cervix**. This finding reminds us of its action on stretch receptors in general. It is probable that it depresses the contraction reflex which originates from the pressure on the cervix. In the course of anesthesia in obstetrical surgery, **the absence of respiratory depression in the infant, and the protection it offers against cardiac anoxia** are also beneficial properties.

As any obstetrician can share, this is a big deal. It is hence, quite tragic this was completely forgotten, so unfortunately the FDA wanted an unconsciousness-inducing version GHB to protect the sleeping pill industry (as GHB was an over the counter supplement that worked for better and more effectively than any of the costly pills we spend billions on each year). In turn, it is **my sincere hope** that research will commence in the next 4 years to rediscover this forgotten medicine and explore how it can be used in childbirth and dramatically improve the somewhat poor results our medical system gets.

Note: due to the general prohibition on GHB, I have very little knowledge direct knowledge of this application (e.g., I only know of limited cases where low-pure-anesthetic/doses were successfully used to ease the birth process, and I know rigor author, who characterized its obstetric effects as "dramatic").

Conversely, while GHB is illegal, homeopathic herbs can sometimes be immensely helpful for facilitating birth and reducing pain throughout the experience. If you decide to pursue this route, I strongly advise working with a midwife or doula familiar with the area.

Vaginal Tears

In most cases, a vaging (and the surrounding tissue) tears because it was pushed too quickly for the childbirth process (e.g., due to pitocin). Presently, I believe the most effective way to prevent this is to have your partner (or a massage therapist) gradually stretch the entire area (using a lubricant such as coconut oil as a lubricant) prior to delivery and to go at a natural pace during labor. Additionally, while I cannot prove it, I strongly suspect that the tissue relaxing properties of GHB prevent tears.

Note: for tears that have already happened, DMSO used appropriately (e.g., at a lower concentration that does not irritate the vaginal can help. Additionally, I sometimes will use the Chinese herb Yunnan Baiyao to reduce bleeding or briefly taking the powder orally. However, if taken orally, it should not be used in conjunction with breast feeding, so there is a bit of a balance to write when to use it (and for that reason it should be done under the supervision of a Chinese medicine doctor familiar with using it).

Birthing Recovery

With vaginal births, the general advice is to use ice and abstain from sexual intercourse for approximately 6 weeks (which is typically a good idea). Rather than use ice, I have found DMSO to be a much better option (both for the abdomen and the vagina). A variety of other things (e.g., homeopathic arnica) can also help. *Note: standard concentrations (e.g., 70% if you tolerate that can be applied to the skin around the vagina and onto the abdomen. This often significantly helps, but if you feel you also need immunologic, start with a much lower concentration and then build it up (typically women find 50% works best but you don't want to start there if you are more sensitive).*

In the case of C-sections, I frequently encounter women who have developed significant chronic issues from the scar they developed from the surgery. In these cases, neural therapy (injecting a preservative free local anesthetic like lidocaine or sometimes bupivacaine into the entire scar to reset the nerves there or prolotherapy (using an irritating substance to provoke an immune response to remodel an existing scar) can be very helpful—even years after the C-section. When this is done, even 4-6 weeks the entire scar is injected with these substances (which is accomplished by having the needle move horizontally through the scar), and typically, neural therapy is used for more minor scars, while prolotherapy is used for thicker scars (that need to get broken down).

Note: you can also use DMSO in this manner, but if you can find a doctor to work with (especially one who feels comfortable with injecting the uterine scar as well, I prefer neural therapy (or prolotherapy as it is faster and more able to address the nerve of the issue.

Lastly, a variety of issues can emerge from the compressions an infant's skull is subjected to, which can only really be fixed by having a manual therapist (e.g., a cranial sacral therapist or an osteopath) work on them. Over the years, I've spoken to quite a few people who do this work and have made a case for why it helps infants (particularly since it's the easiest to remedy while it's still soft).

On a practical level, I've seen these treatments often significantly help with breastfeeding difficulties (as the nerve infants need to feed often gets compressed by the delivery process). I've also noticed that whenever I meet someone who appears to have issues arising from significant birth trauma, they never report having received any type of manual treatment for their head as an infant. Overall, since this type of manipulation is harmless and can sometimes create significant long-term benefits, I recommend it if someone in the area provides it and is familiar with treating infants.

Cord Blood Banking

Since umbilical cord blood cells are so useful, many individuals chose to bank them in case they are needed in the future, particularly since it is ideal to get them from yourself, and in turn both public and private services exist to bank them, with private ones (you pay for) being the only way you can later withdraw them to use as needed. From having explored the available options, we believe Miracle Cord is the best option.

Note: since this costs a couple thousand dollars, and many of the cells go unused, you should communicate with an integrative doctor who is familiar with the subject to decide if you want to make the investment.

I personally believe preserving the cord blood for banking is one of the few reasons to consider not doing delayed cord clamping (so that the blood can be preserved for the banking), but typically when this choice arises, I will wait until the cord pulsing stops (and it feels like the flow has stopped inside the cord and just make do with a lower harvest of cord blood for the banking (which is often still somewhat sufficient—miracle cord for example can still make due with delayed cord clamping).

Additionally, while it is possible to also bank the placenta, in most cases I believe there is more benefit (and less cost from simply encapsulating the placenta and eating it after the blood within it has been extracted (assuming you pred bank). *Note: many resources exist for mothers who wish to encapsulate the placenta (e.g., many midwives and doulas can help you with it).*

Turning Babies

The standard procedure for turning a breech baby (an external cephalic version) is done by having an obstetrician monitor the baby (e.g., its heart rate) and then use gentle abdominal pressure to turn the infant around (which works roughly half the time).

Alternatively, I have also seen:

•Acupuncturists use specific points in the feed to turn the baby.

•Body workers work on the fascia within the abdomen to reposition the baby.

•The mother be tilted so that her feet are above her head to disengage the baby from the pelvis so it is free to move), and then place an ice pack on the abdomen near the baby's head (as the baby will frequently move away from the cold).

Each of these approaches can work, but the ice approach offers the advantage of not being particularly dependent on the practitioner's skill whereas the other two options are.

Note: in some cases it is not possible to turn the baby because of abnormal positioning of its blood supply, which results in it being partially cut off when the baby is turned (which is why obstetricians monitor the fetal heart rate while attempting to turn the baby). If other approaches do not work, this needs to be considered as a reason why the baby does not want to move.

Prenatal Care

When aiming for a healthy pregnancy, there are both principles and specific methods to adopt. For example:

•Your health prior to the start of the pregnancy will impact the health of your child, so we emphasize ensuring an adequate preparatory phase can be conducted.

•It's critically important to take the pregnancy seriously.

•Any stress or emotional toxicity a mother experiences during the pregnancy can imprint onto the child. As such, while it is impossible to avoid every stressful situation, doing as much as possible to create a safe and supportive environment for the mother and cutting out any emotionally toxic people from her life will pay significant dividends for the child.

Preparing for Pregnancy

During the pre-pregnancy phase, we view things as critical to focus on:

•Any things the mother had put off to improve her health (e.g., regularly exercising—ideally by swimming if available, and getting sunlight).

•Have the mother in a good emotional and physical state for the pregnancy (e.g., we will often have them work with an Emotional Code practitioner if there are retained traumatic emotions that could potentially be problematic).

•Begin nutritionally fortifying her. Typically, we find the most important one is Standard Processes's (SP) Rhodizo (normally around 6-7 a day). In addition, Life Extension 0.81 PTP, SP Wheat Germ Oil, SP Folate B-12, Nature's Way Vitamins A (especially between pregnancies), SP Manganese B-12, SP Zinc Liver Chelate and the fatty parts of most naturally grass-fed beef; can also be needed. *Note: the appropriate dose varies significantly from person to person, and we typically determine it (and what's needed) from muscle testing or comprehensive nutritional tests like InnerVital, so I cannot provide exact doses, but typically we have people on 2-3 supplements during the prenatal period.*

•In many cases, nutritionally fortifying the man prior to conception is also important (typically with Rhodizo, Wheat Germ Oil, and Zinc Liver Chelate). *Note: if at all possible, you also want to minimize EMF exposures to the mother, but the most obvious effect many notice from EMF avoidance is the ability of men to conceive due to EMFs adverse effects on the sperm.*

•Make sure the has optimal thyroid levels (as while hypothyroidism is linked to a variety of overt issues in infants, subsyndromal thyroid levels can create a variety of more subtle issues). Similarly, we try to optimize progesterone levels (although the vaginal suppositories are much more important).

•Eliminate excessive heavy metals (as during pregnancy, these will concentrate in the fetus). We typically address this through giving an IV push of a very low dose of (aluminum free) EDTA every few weeks with zinc, manganese (which should be taken every other day), and magnesium being taken concurrently (so they do not get depleted), but a variety of other chelation protocols (e.g., oral ones) can also work that many have had success with. *Note: it is important to step this protocol once you are actively trying to conceive and ideally to have a gap period between the two where you replete the essential minerals EDTA will chelate which is typically the 12 months I just listed like marriages).*

Preventing Miscarriages

A variety of things are taught for how to avoid miscarriages (e.g., avoid alcohol and drugs, don't have excessive stress), but out of all them, we find the **single most important one** is vaginal suppositories of progesterone (which is somewhat suppressed by the evidence). In turn, our experience has been that when progesterone is used throughout pregnancy, it is extremely rare for miscarriages to occur unless the fetus is non-viable in the first place, as is a serious defect.

Note: progesterone is the hormone responsible for maintaining pregnancy, and we believe a key reason why older women are at a much higher risk of miscarriages is that progesterone levels decline with age in a manner that directly parallels the increased risk of miscarriages.

That said, when vaginal progesterone is used, it is **critically important** not to abruptly discontinue it, as we have seen progesterone withdrawals trigger miscarriages.

The dosing schedule we typically use is 1-3 100mg progesterone suppositories twice a day (with the exact amount being determined by their prenatal history, age, adrenal function and stress levels)—which frequently works so well 3 of them twice a day. This dose is maintained for the first two trimesters. In the third trimester, it is then gradually decreased every 2-3 weeks (e.g., by having a day be skipped each week, and then after a few weeks, skipped on another part of the week).

Note: magnesium also helps prevent preterm labor, while I believe excessive ultrasounds can cause it.

Common Pregnancy Issues

During pregnancy, numerous structural changes happen in the body which significantly increase the likelihood of mothers having musculoskeletal issues. In addition to the increased weight on the body, we find some of the most problematic ones are the systemic ligamenous laxity of the body (which is necessary for the pelvis to be able to expand to accommodate the birthing process), the increase of retained fluids (edema) throughout the body, and the psoas getting pressed upon by an ever expanding uterus.

Regarding the ligamenous laxity, the best solution we've found is to have the mother receive regular manipulative treatments (ideally of a gentle nature).

Regarding the edema, a variety of approaches work and we often find taking either Zeta Aid (for the sera potential) or SP AC Carbonitale can be quite helpful. Additionally, in some cases, 0.81 PTP can be quite helpful.

In regards to the back pain, while manipulation can help, we frequently find the root cause is from the psoas, and in turn stretching (e.g., with lunges) can often be immensely helpful to reduce.

With pre-eclampsia, I have developed a strong suspicion that it results from insufficient blood flow entering the uterus and in turn, that treatments to improve blood flow to the uterus (e.g., Viagra, Cialis, or the nitroglycerin patch) can be quite helpful.

blood flow to the uterus (e.g., Zica and to improve zica potentials can be quite helpful. Additionally, we also find taking magnesium starting in the second trimester of the pregnancy (e.g., one of these LE ones twice a day and increasing it if cramping occurs) along with epsom salt baths, and in some cases (LE) P5P can be quite helpful.

Note: to some extent, pregnancy is a blood clot, so it's not wise to do too much to improve blood flow (e.g., many anticoagulants are known for causing abortions). Similarly, Chinese Medicine views pregnancy as blood stagnation, and cautions against using blood mobilizing herbs during pregnancy.

Pregnancy Nutrition

During the pregnancy, exactly what supplements mothers need varies (which is why I am hesitant to write any exact protocols) but we find 1-10 capsules of SP Biodent are needed (if in doubt go on the upper end) is almost always needed.

Additionally, B6 (LE P5P) typically is needed, with the ideal dose having a fairly wide range (hence requiring it to be carefully monitored), SP Folate B-12 (or an equivalent preparation) is normally necessary, and in some cases, zinc is also needed.

Finally, we believe the best source for fat-soluble vitamins are from foods, so if possible, we advise mothers to eat as much liver as they crave, 1-4 times a week, and to eat lots of (ideally raw) butter (2 tablespoons 1-2 times a day).

Note: a well balanced (and ideally organic) diet with a lot of protein is important for pregnancy. To this end, it's important not to get stuck on a specific diet (e.g., rigidly forcing yourself to only eat raw vegan foods while pregnant) and instead prioritize the nutrients your child will need.

Conclusion

When writing this article, one of the significant challenges I faced was having it be the appropriate length, as this time in our lives is so vital for both us and our child, but simultaneously, there are so many factors that make it far more challenging than it needs to be. In writing this, I hoped I could provide most of the critical information (and the data behind it) and give you an idea of what it's like to go through this. Still at at the same time, I feel I only scratched the surface of this and it's difficult for people to understand unless they've been through it.

Note: I sometimes share two excellent documentaries on the birthing industry with patients that can be helpful for parents to watch (The Business of Being Born and Why Not Home) so they can better understand what they are venturing into.

Because of that, it is absolutely critical when you go into the birthing process that the father at least has an understanding of what you will go through and is prepared to support you in a way that helps. Fortunately, since there is a robust midwifery community in the USA, that support will often be there for you, and they can often guide both of you through the process.

Likewise, while I still have major issues with how the profit (and time) driven system of birthing works in the United States, I must acknowledge that things are much better now than they were in the past. As such, it is my sincere hope that both the MAHA moment and the economic pressures of mothers choosing to deliver at home (which costs hospitals business) will create the momentum for a healthier and more integrated birthing system and I deeply thank each of you for helping to make this shift happen.

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Rosie Cotton Rosie Cotton Feb 16

Liked by A Midwestern Doctor

I've birthed 10 children vaginally:

First one at a military hospital where they "stripped my membranes" - absolutely the worst experience of the 10. It's a miracle I was willing to try again, in my naivetê.

2,3 and 4 - traditional hospital birth with epidural. Had weird symptoms after pitocin and hard time dealing with an episiotomy. (or two?)

5, 6, 7, 8 - home births with a midwife. Wonderful, excellent experiences. Sometimes tearing, but no problem stitching up without anesthesia if done quickly - all the blood has been "pushed away"; so there is little feeling in the perineum. Baby 8 had a undiagnosed heart defect (only one sono done at 8 weeks) and Down Syndrome, and had to be rushed to ER, but I believe the vaginal home birth saved her life. It is certain, if I had had her in a hospital, they would've required a c-section.

9, 10, - had at a birthing center, water births. Absolutely lovely option - most comfortable way I birthed. I was 47 years old with the last one, and was considered "high risk" solely because of age.

Experienced midwives are picky about their clients and I believe that is another reason why homebirths are so safe. If there is an issue with baby's or mother's health, they will recommend hospital birth.

Thank you for another fabulous, informative article AMD. You are doing an amazing job!

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1 reply by A Midwestern Doctor

Obcwcvh Obcwcvh's Substack Feb 17

Liked by A Midwestern Doctor

It makes me viscerally sad to see how many people are turning towards surrogate pregnancies, as if the child birthing journey is just a "nuisance" of no importance. I feel like this trend is enoding away at what it means to be human; as the human birthing process, and even more so the human parent-child relationship, is quite unique within the animal kingdom.

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4 replies by A Midwestern Doctor and others

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