Childbirth: What to Reject When You're Expecting

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Despite the benefits of a healthcare system that outspends those in the rest of the world, infants and mothers fare worse in the U.S. than in many other industrialized nations.

Infants in this country are more than twice as likely to die before their first birthday as those in Japan and Finland, and America lags behind nearly every other industrialized nation in preventing mothers from dying due to pregnancy or childbirth. The U.S. is one of only a handful of countries in the world, including Afghanistan and South Africa, whose maternal mortality rate is rising.

Why? There are no doubt many causes. But one likely contributor may be that medical expediency often takes priority over the best outcomes and evidence-based treatments. And while there are signs of improvement in several parts of the country, other areas still have lot of work to do.

Over the past few decades, the U.S. healthcare system has developed into a labor-and-delivery machine, often operating according to its own timetable rather than the less predictable schedule of mothers and babies. Keeping things chugging along are technological interventions that can be lifesaving in some situations but also interfere with healthy physiological processes and increase risk when used inappropriately.

One example: The nation's continued high C-section rates. Nearly one of every three American babies enters this world through a surgical birth. But when C-sections aren't medically indicated, they may be more likely to harm mothers and babies than to help them.

Aaron B. Caughey, M.D., chair of the Department of Obstetrics and Gynecology at Oregon Health & Science University School of Medicine in Portland, points out that as the rate of cesareans in the country increased over the past several decades, the country did not see fewer deaths among newborns. "In fact, if anything, we started to see an increase in maternal mortality," he says.

The idea, of course, is not to reject all interventions. Childbirth is not something that anyone can completely control. In some situations, inducing labor or doing a C-section is the safest option. And complications are the exception, not the norm.

But when they're not medically necessary, research shows that the interventions listed below are associated with poorer outcomes for mothers, babies, or both.

1. A C-Section With a Low-Risk First Birth

While C-sections generally pose few risks, “the safest method for both mom and baby is an uncomplicated vaginal birth,” says Catherine Spong, M.D., deputy director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

The best way to reduce the number of C-sections overall is to decrease the number of them among low-risk women who are delivering their first child. That’s because having an initial C-section “sets the stage for a woman’s entire reproductive life,” says Elliott Main, M.D., medical director of the California Maternal Quality Care Collaborative, a nonprofit organization that works to improve childbirth. “In this country, if your first birth is a C-section, there’s a 90 percent chance all subsequent births will be as well,” he says.

A C-section is major surgery. So it’s no surprise that as rates for the procedure go down, so do the numbers for several complications, especially infection or pain at the site of the incision. A C-section can also complicate future pregnancies, increasing the risk of problems with the placenta, ectopic pregnancies (those that occur outside the uterus), or a rupture of the uterine scar. And the risks increase with each additional cesarean birth.

In some situations, such as when the mother is bleeding heavily or the baby’s oxygen supply is compromised, surgical delivery is absolutely necessary. And there are non-emergency situations where a C-section may be the best pathway, such as when the baby is feet first, or when there is more than one baby. But most women can maximize their chances of avoiding an unnecessary cesarean by finding a caregiver and birthing environment that supports vaginal birth.

When choosing a practitioner and hospital or birth center, ask about its C-section rates, particularly rates for low-risk deliveries. Use our hospital ratings to find cesarean rates of hospitals near you. A Consumer Reports analysis of 1,300 hospitals found that more than half of hospitals have C-section rates that are higher than the national target. And read more about how to cut your odds of having an unnecessary C-section.

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2. An Automatic Second C-Section

Just because your first baby was delivered by cesarean doesn’t mean your second has to be, too. In fact, many women who have had a prior C-section are good candidates for a vaginal birth after cesarean (VBAC), according to The American Congress of Obstetricians and Gynecologists (ACOG).

Yet the percentage of VBACs has declined sharply since the mid-1990s, particularly after ACOG said in 1999 that they should be considered only if hospitals had staff “immediately

available" to do emergency C-sections. Some obstetricians don't do VBACs because they lack hospital support, or because their malpractice insurance won't provide coverage.

So women seeking a VBAC delivery might have trouble finding a supportive practitioner and hospital. Some hospitals have a policy against trial of labor after cesarean. "It's tragic, really," Main says. "In many parts of the country, the option has all but disappeared."

In response, ACOG recently relaxed its guidelines. For example, it now makes clear that while it's preferable for staff to be at the ready, hospitals can make do with a clear plan for dealing with uterine ruptures and assembling an emergency team quickly.

Although some women turn to home births as an alternative, our experts say that isn't a good idea in this situation. "The risk of uterine rupture is low," Main says, "but if it happens, it can be catastrophic."

Instead, if you have had a C-section, find out whether your obstetrician and hospital are willing to try a VBAC. Let them know that you understand that your baby will be monitored continuously during labor, and ask what the hospital would do if an emergency C-section became necessary.

3. An Elective Early Delivery

Of course, some babies arrive sooner than expected and complications during pregnancy, such as preeclampsia (high blood pressure in the mother), can make early delivery the safest option. But hastening the birth of an otherwise healthy baby—even by a couple of days—is not a good idea.

"Important fetal development takes place to your baby's brain and lungs during those last few weeks of pregnancy," says Leah Binder, president and CEO of The Leapfrog Group, a nonprofit organization that advocates for improved quality and safety in the U.S. healthcare system. Babies born at full-term, which is at least 39 weeks, have lower rates of breathing problems and are less likely to need neonatal intensive care.

Perhaps because late preterm infants have more problems, mothers are more likely to suffer from postpartum depression. In addition, the procedures required to intentionally deliver a baby early—either an induced labor or a C-section—also carry a higher risk of complications than a full-term vaginal delivery.

Yet rates of these scheduled births skyrocketed in the early 2000s, to the point that almost 17 percent of births were scheduled before 39 weeks. In response, ACOG and a number of other groups—including the American Academy of Pediatrics, the American College of Nurse Midwives, the American Hospital Association, and the March of Dimes—initiated a campaign to sharply reduce early elective deliveries.

The effort was spectacularly successful: Rates dropped to 1.9 percent in 2016.

4. Inducing Labor Without a Medical Reason

Even after 39 weeks of pregnancy, you should resist the urge to induce labor unless there is a strong medical reason, says Debra Bingham, a doctor of public health and associate professor for Healthcare Quality and Safety at the University of Maryland School of Nursing.

She points out that women who go into labor without being induced can usually spend the early portion at home, moving around as they feel most comfortable. An induced labor takes place in a hospital, where a woman will be hooked up to at least one intravenous line and an electronic fetal monitor. In addition, most hospitals don't allow eating or drinking once induction begins.

"Undergoing medical procedures or taking medications without a medical indication causes more harm than good," Bingham says. "It's similar to taking blood pressure medicine when you don't have high blood pressure. The medicine is good when needed, but more harmful to you if you don't have a medical condition that will benefit from this medicine."

Caughey, at ACOG, agrees. "There is little evidence to support an induction" without a clear medical indication, he says.

Talk with your provider to determine if you really need to be induced. And recognize that induction increases the risk of other interventions, such as needing an epidural for pain relief.

Good reasons for an induction: you develop a complication such as high blood pressure; your "water breaks" without labor starting; or you're at or beyond 42 weeks pregnant.

5. Ultrasounds After 24 Weeks Without a Medical Reason

Unless there is a specific condition your provider is tracking, you usually don't need an ultrasound after 24 weeks. Although some practitioners use ultrasounds after this point to estimate fetal size or due date, the margin of error increases as the pregnancy progresses. And the procedure doesn't provide any additional information leading to better outcomes for either mother or baby, according to a 2009 review of eight trials involving 27,024 women.

6. Continuous Electronic Fetal Monitoring

Continuous fetal monitoring, during which you're hooked up to a monitor to record your baby's heartbeat throughout labor, is recommended if you're given oxytocin (a drug that strengthens labor), you've had an epidural, or you're attempting a VBAC.

If it's not medically necessary, however, continuous fetal monitoring doesn't reduce the risk of cerebral palsy, death, or other negative outcomes for your newborn, research suggests. But it does restrict your movement, and increases the chance of a cesarean delivery.

The alternative is to monitor the baby at regular intervals using an electronic fetal monitor or a handheld ultrasound device.

7. Early Epidurals

An epidural places anesthesia directly into the spinal canal, so that you remain awake but don't feel pain below the administration point. Unfortunately, the longer an epidural is in place, the more medication accumulates, making it less likely that you will be able to push.

Epidurals can also slow labor. By delaying administration and using effective labor support strategies, you might be able to get past a tough spot and progress to the point where you no longer feel it's needed.

If you do have an epidural, ask the anesthesiologist about a lighter block. "Ideally, a woman should still be able to move her legs and lift her buttocks," Main says.

8. Routine Episiotomies

Practitioners sometimes make a surgical cut, called an episiotomy, just before delivery to enlarge the opening of the vagina. Episiotomies can be necessary in rare situations where a rapid delivery needs to occur due to fetal distress.

But in other cases, routine episiotomies don't help and are associated with several significant problems, including more damage to the perineal area (the area near the rectum) and a longer healing period, according to a 2009 review involving more than 5,000 women.

9. Automatically Sending Newborns to the Nursery

If your baby has a problem that needs special monitoring, then sending him or her to a nursery or even an intensive care unit is essential. But in other cases, allowing healthy infants and mothers to stay together promotes bonding and breastfeeding.

Moms learn to respond to the feeding cues of their babies, and having babies room in with

their mothers strengthens the maternal-infant bond. Allowing mothers and babies to stay together is one of the criteria hospitals must meet to be certified as Baby-Friendly by the Baby-Friendly Hospital Initiative, a program sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).

At the same time, if you need a break from a fussy baby, particularly if you're recovering from a cesarean or a difficult delivery, do not hesitate to ask the nursing staff for help with your newborn.
