Thank God for kidney stones! These tiny pieces of gravel can cause in a man the only pain that a woman might admit hurts as bad as childbirth. Without kidney stones, we men would forever be cut off from attaining the level of suffering that women do when they birth us, leaving uncontested women’s superiority when it comes to suffering.

There is a lot more to the experience of childbirth than pain, something the medical profession has come around to admitting only recently. As a medical student in the early 70’s here’s how I learned to do deliveries. When birth was imminent the laboring woman was slid from her hospital bed onto a gurney and wheeled, posthaste, down the hall to a delivery room, a space that was indistinguishable from an operating room, with tile walls, stainless steel cabinets, surgical lights, and a narrow and uncomfortable delivery table. The mother-to-be was transferred from gurney to table where she lay flat on her back with her legs strapped into stirrups, knees in the air, wide apart. Sometimes her arms were tied down too with leather restraints. Her bottom was doused and scrubbed with copious quantities of soapy water, then painted with iodine. The doctor and nurses were fully covered by surgical cap, gown, and face mask and the patient was draped with sterile sheets up to her chest.

The mother might receive any of a number of pain relief measures, including inhalation, local, and spinal anesthetic. Being strapped into such an unnatural position made anesthesia all the more necessary.

As the baby was crowning we always cut an episiotomy, an incision made with a big scissors, usually without anesthesia, through the stretching and thinning vaginal tissues. This was supposed to prevent uncontrolled tearing of the tissue and prevent urine and bowel problems later in life. (Studies have since shown, as with so many other elements of the old delivery protocol, that there is no benefit to routine episiotomy).

As soon as the baby was delivered the cord was clamped and cut and the child was carried to a table to be dried and checked and, if necessary, resuscitated, then whisked off to the nursery. If the mother was awake, she might be given a glimpse of her newborn on its way out the door. Meanwhile, further south, her doctor labored to sew up the episiotomy and worried over the
placenta which, if it didn’t deliver spontaneously in ten minutes or so, he (*sic.*—most doctors were men in those days) stuck his gloved hand all the way up into the uterus to remove it manually, which they tell me is about as painful as it sounds.

And that’s just the delivery. Labor was plenty uncomfortable too, starting with a shave from bellybutton to knees and an enema upon arrival at the obstetrical ward. The mother was allowed nothing by mouth, not even a sip of water, even if the labor lasted two days. She was tied to the bed by monitors that graphed her uterine contractions, beeping or clicking with each of the baby’s 140-160 heartbeats a minute. If the monitor failed to pick up the heartbeat, which happened frequently, there was a scary silence for the mother to contemplate, alone in her bed (fathers were banished to the waiting room). When the delivering physician dropped in to see how the labor was progressing, he usually walked to the fetal monitor machine and looked at the graphed output before he looked at the patient.

Things are better now; far from perfect, but better. Most women deliver in nicely appointed birthing rooms, unrestrained, on comfortable beds, with little or no shave, staff comfortably dressed in simple scrubs, music of choice, low lights, rooming-in with the baby, family present, some nourishment during labor, no routine enema or episiotomy, etc. And outcomes are better than ever.

Do you know why labor and delivery are more gentle now? Not because the medical profession wanted these changes. Obstetrics used to be practiced according to good medical principles, including: sterile technique; technological monitoring; and doctors making all the decisions. It took feminism to teach women that they had every right to expect to not be alone, strapped down, flat on their backs with legs in the air, when they gave birth.

Let’s give doctors a break, though. The birthing movement isn’t about good women pitted against evil doctors. Physicians, while trying to practice the best obstetrics we can, have long been afraid of being sued, which happens a lot, especially in obstetrics.

Everybody, even physicians, makes a mistake now and then. When a doctor doesn’t err, the patient may still believe he did if the outcome is a less than perfect newborn. Every time a baby doesn’t come out just right the doctor is at risk of having the parents, armed with a lawyer, come at him for millions. The appearance of a heart-wrenching “damaged” kid before a jury of sympathetic laypeople has opened many a floodgate of damages, deserved or not.

How do doctors react? We practice with one eye on creating a legally defensible medical record just in case, God forbid, mother or child suffers a complication while under our care.

The trouble is, practicing to avoid being sued is not necessarily practicing good medicine. Routine fetal monitoring is an example of doing too much for the wrong reasons, a holdover from the bad-old-days of doctor-centric obstetrics. To be sure, if a pregnancy is deemed high risk--prenatal complications such as inadequate weight gain, diabetes or elevated blood
pressure; labor either before or after the ideal time window around term; history of problems with other pregnancies; extremely young or old mother; inadequate prenatal care, etc.—then strapping those instruments around the mother’s belly could identify fetal distress early and lead to medical or surgical interventions that might save the baby’s life and its brain tissue.

But in the case of low risk pregnancies fetal monitoring changes only one outcome, the rate of invasive intervention. Low risk mothers and babies don’t do any better because they have been monitored. They just get more forceps and suction deliveries and Cesarean deliveries. The more you intervene, the higher the expense and the bigger the risk of complications.

On just about every obstetrical ward in the country, the practice is to run a 20- or 30-minute baseline fetal monitoring strip on every woman who presents to the hospital in labor. If the strip looks benign and the labor progresses smoothly she won’t have to stay hitched to the monitor machine. But if the strip doesn’t look so reassuring, she is doomed to spend her labor hitched to a bed so the baby can be scrutinized electronically. And her risk of forceps, suction or c-section delivery is enhanced without increasing the odds of delivering a normal child. Why, then, do doctors still insist on doing baseline fetal monitoring strips on low-risk mothers? Because they’re afraid not to do it. They’re frightened that, without fetal monitor evidence, some lawyer will ask them, under oath, “How did you know then, Doctor that the baby was not in distress at this point in the labor?” (“Doctor” is pronounced here as if the lawyer had a turd in his mouth. I know because I’ve been there.)

Fetal monitor interpretation is just that, interpretation, a very inexact science. Studies show that monitor strips are as likely to hurt a doctor’s malpractice defense as to help it. So I ask again, why do doctors insist running baseline strips on low-risk women? Because we tend to put more faith in technology than we do in anything else.

Study after study has shown that a good relationship with the patient, real two-way communication, is the best protection from being sued for malpractice. Unfortunately, doctors are not trained to be communicators. We are trained to be scientists; to trust, above all, in numbers and technology. (This is the reigning vision of medical science, an unnecessarily narrow vision, but that’s another discussion.) When doctors feel insecure we interpose more machines and tests and procedures between ourselves and our patients. The more we interpose, the worse we communicate, and the more likely we’ll get sued.

An encounter with a “demanding” pregnant woman is one of the most surefire triggers of doctor insecurity. Here’s a diabolical vicious cycle: patients expect more control of the birthing process; doctors react defensively and surround themselves with more technology; technology gets in the way of the doctor-patient relationship; women, mad about being objectified and technologized, sue their doctors; doctors who are sued feel insecure so they adopt more technology; etc, etc. Halting this cycle comes down to human relationships, not to science, not to technology.
So, women (and men), don’t stop negotiating with your doctors about how you want your labor to go. Build a relationship with her (sic.—today many doctors who deliver babies are women). There is not one right way to have a baby. "Natural" is fine. So is pain control. Sound medical practice encompasses a much wider territory than many doctors yet recognize.

I’d like to leave this piece where I started, with a story about the pain of labor and delivery. I saw this narrative at a museum, was depicted on a mola, a panel made by an indigenous people of Panama. Molas are created by overlaying multiple layers of brightly-colored cloth, cut out to portray scenes and symbols in psychedelic splendor. The caption to the exhibit item explained that it represented a childbirth practice of the tribe. The laboring woman would squat under a tree. Perched above her, on a limb of the tree, was the father of the child-to-be, with a rope tied around his scrotum. When the mother’s labor pains would get bad, she’d tug on the rope so she could share the discomfort with her husband.

I’ve never described this practice to an American woman who didn’t think it was a good idea. Maybe passing a kidney stone isn’t so bad after all.