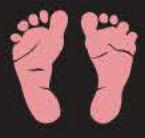
# WE'VE COME A LONG WAY Baby

## Birth outcomes and expanding birth options in New Orleans



BY CLAUDIA S. COPELAND, PhD

>> Before the middle of the twentieth century, giving birth in Southern Louisiana was a uniquely homey affair. Dominated by French-speaking Cajun and Creole midwives, midwife-assisted birth at home was not only the norm in rural areas, but also within the city. According to Maida Owens of the Louisiana Folklife Project, in 1915, when the rest of the United States employed midwives for less than 30% of urban births, midwives delivered 85% of the babies in New Orleans. Trained through an informal process of apprenticeship based on lineages of women practitioners, these midwives were esteemed on the basis of their individual reputations and experience rather than a system of credentials. >>

**IN THE 1920s,** this organic system began to integrate with more formal systems based on medical training. Midwifery became supervised by the public health system, with meetings between public health nurses and lay midwives, who often used the meetings to educate each other through the exchange of techniques and ideas. The nurses educated the midwives in issues of sanitation, inspected their equipment, and gave them supplies such as silver nitrate to prevent eye damage in newborns due to STDs, but they did not do any obstetric training. All childbirth education was received from other midwives, outside the realm of formal medicine, and they retained a view of birth that was more personal than medical, and often strongly spiritual.

In those early days, many women preferred midwife-based birth to care by a physician; they felt uncomfortable with the medical approach and physical intimacy of obstetric care by a male doctor, and appreciative of the warmth of the midwives and their greater attentiveness and support. For other women, however, midwife-based birth represented not a preference, but a lack of any other options. With physicians sparse and the demand for labor assistance great, many women had little choice in the matter. Physicians generally would not assist women who could not pay for their services or who were working in the United States illegally, unless a life-threatening emergency arose. In contrast, midwives generally practiced in answer to a "call from God" or in response to dire need in their community. They treated everyone, often receiving payment in the form of bartered items such as quilts or farm produce. The midwives performed an extremely important service in caring for these women, but while they did the best they could, there were cases that clearly warranted a more medical approach.

One example was related by Rosie, a midwife born in 1892 who began practicing in the 1930s in response to a desperate need for midwives in her community. She described a breech birth by a mother who was an illegal migrant worker. The husband had not wanted to call a doctor because of fear of deportation, and when Rosie did call the local physician upon learning that the baby was breech, he instructed her to deliver it herself. She did so without formal training or modern facilities. In her words, "I had to do it, so I did. I had to take my hand and get that other foot. That was a big, old live baby."

Rosie managed to deliver this breech baby successfully, but delivery of such a baby under primitive conditions is very high-risk, and while many public health nurses credited the midwives with successfully dealing with difficult situations, physicians were often more critical. Fetal death rates before 1950 were higher in Louisiana than the national average, and while these rates had dropped substantially upon adoption of modern sterilization techniques by the midwives, physicians frequently felt that the midwives contributed to fetal and maternal deaths. In the 1950s, several factors converged to revolutionize the experience of birth in Louisiana. An increased supply of doctors, combined with a cultural association of midwife-based birth with poverty and the consequent desire for a "modern hospital birth," decreased the demand for midwives, and the number of young women apprentices learning the craft declined sharply. Thanks to the State Board of Health's expansion of charity hospital-based free clinics, more poor women were able to receive obstetric care from doctors as well.

Today, there are enough formally trained obstetricians and obstetrical nurses to provide services for all New Orleanians. Further, the LaMOMS program—a Medicaid-based program that provides prenatal and obstetric care to mothers who cannot afford private insurance—has afforded all legal residents of Louisiana the choice of state-of-the-art obstetric care. The impact of this program cannot be overestimated—currently, it pays for 70% of Louisiana births, enabling women here to feel truly confident that they can get the care they need during pregnancy and delivery, regardless of their income.

New Orleans is currently well-equipped to deal with medical emergencies and high-risk pregnancies. An array of hospitals in the area offer epidural anaesthesia, surgery, and neonatal intensive care. Experts such as maternal-fetal medicine specialists and neonatologists ensure that unusual obstetrical problems and emergencies can be addressed by well-trained staff. Specialized procedures available today, such as intrauterine fetal transfusions, would be unthinkable during the early days of "modern" birth. State of the art neonatal intensive care is also readily available in the city. Ochsner, Touro, and Tulane-Lakeside hospitals offer Level III-Regional Neonatal Intensive Care Units, the highest level designation awarded by the state. The Ochsner team alone admits approximately 350 newborns annually, one-third of them transported from other hospitals. These NICUs include medical and surgical subspecialists, state-of-the-art technology, and amenities that ensure that newborns will have the best possible intensive care.

In spite of the availability of first-rate obstetric and neonatal technology and expertise, however, Louisiana's rate of infant mortality is third-highest in the nation (and infant mortality in the United States is higher than in most developed countries). Moreover, the fetal death rate in Louisiana remains above the national average, and Louisiana has one of the highest maternal mortality rates in the United States. Clearly, there are problems leading to poor maternal/fetal outcomes that are not being solved by state-of-the-art obstetrical facilities.

The Louisiana Department of Health and Hospitals has stepped in to address this issue from a public health perspective. Through a program called the Birth Outcomes Initiative, the DHH is spearheading efforts to reduce the state's high infant mortality rates, and also an unacceptably high rate of prematurity. Measures to address this include public health programs to reduce smoking among pregnant women and medical initiatives such as the promotion of 17-hydroxyprogesterone, which has been successfully used to prevent repeat preterm births.

Ironically, the easy availability of medical intervention has led to its own problems. According to the DHH, Louisiana ranks fourth in the nation in cesarean sections per live births, with C-sections steadily rising, accounting for 36 percent of births as of 2007. Many of these are elective, or associated with early induction. According to the DHH, elective early inductions and C-sections lead to increases in low birth weight and NICU admissions. One way to address this issue is through reform of the pay structure of Medicaid, which pays for the majority of Louisiana births. By increasing the compensation rate for non-induced vaginal birth, DHH Secretary Bruce Greenstein hopes to lower the rate of elective early birth, the number of unnecessary C-sections, and the rate of premature birth. In addition, the 39 Week Initiative, a voluntary program in which hospitals agree to establish policies to end the practice of elective, non-medically indicated deliveries prior to 39 weeks gestation, has shown great potential for success, especially when combined with financial incentives. At Woman's and East Jefferson hospitals, Secretary Greenstein reported that "with no new investments, these hospitals dramatically decreased elective early births. At East Jefferson, the number went from more than 500 to 18. Since implementing the initiative at Woman's, the admissions into the neonatal intensive care unit dropped 20 percent. We need to replicate those results using the tools we have in Medicaid to make it work." All 58 birthing hospitals in the state have now joined the 39 Week Initiative.

Aiding in this effort, in April of 2012, the Louisiana Electronic Event Registration System (LEERS) was enhanced to include data on births that occur before the 39th week of pregnancy. This will provide valuable data that will help the state to improve birth outcomes by facilitating the development of evidence-based policies. According to Dr. Rebekah Gee, who directs the Birth Outcomes Initiative, "Today, we know that Louisiana ranks 48th nationally in infant mortality and preterm birth, and 49th in the percentage of low birth weight and the percentage of very low birth weight babies, but we don't have the data necessary to understand why. This change will move the state's vital records system from measurement to action, empowering the Department to create meaningful policies." Such data will also aid in the development of two other goals of the Birth Outcomes Initiative: the creation of a Louisiana "Report Card for Maternity and NICU care," and the creation of "Centers of Birthing Excellence" based on a five star program to be determined in partnership between DHH and Louisiana's birthing hospitals.

While reduction of fetal and maternal mortality and morbidity is of top importance, many women feel that it is important to have a positive birth experience as well. A mother's birth

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Louisiana

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*Practitioners, Kelly Toups, APRN, CFNP and Jessica Smith, APRN, FNP-C*

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experience can have a profound effect on her sense of bonding with the baby and her sense of strength and empowerment during the physically and emotionally taxing time of caring for a newborn. One mother expressed her frustration at not being allowed, because of her insurance plan, to deliver with the obstetrician who delivered her first baby. "It's a very intimate thing; it's a big deal. I know him, and I just loved having him as my doctor. I want him to deliver my baby, not someone else, even though I'm sure they are qualified." In addition, even among mothers who were very happy with their pregnancies, the hormones, lack of sleep, and overwhelming round-the-clock effort required to care for a newborn can lead to feelings of profound sadness, commonly called the "baby blues." In about 10% of childbearing women, this develops into postpartum depression, a serious mental disorder. In addition to valuing a positive birth experience for themselves, many women are even more committed to a positive experience for their baby. Such women feel that the strong drugs used for obstetrical anaesthesia and traditional medical procedures, like bright lights and taking the baby away to the nursery immediately after the birth, are inappropriate and traumatic for a newborn baby.

For these reasons, many women are turning back towards a more natural style of birth. Fortunately for these women, such an alternative is now safely available: birth led by a licensed midwife. According to a 2012 review of birth outcomes by the American College of Nurse-Midwives, midwife-led care is associated not only with greater satisfaction with the birth experience, but also with lower rates of labor induction, higher chances of vaginal birth, reduced risk of preterm birth, and higher chances of a successful start to breastfeeding. New Orleans facilities are becoming increasingly supportive of mothers who want this option. Both Touro and Ochsner provide spacious labor rooms for low-risk women, welcome birth plans and doulas (support professionals for natural labor), and offer childbirth classes. Touro has been particularly supportive of natural birth, offering innovations such as a room with a built-in birthing tub for water births. According to Esther deJong, a certified nurse-midwife who has been practicing in New Orleans for 25 years, Touro currently offers the most supportive environment for natural birth. In addition to "lovely" rooms, with natural light and showers in every room, they use monitors that are wireless and submersible and the nurses there seem to really like this kind of birth.

Along with her colleague, Catherine Badeaux, also a certified nurse-midwife, deJong owns Woman to Woman Midwifery, the only independent midwifery practice in New Orleans. While they are associated with Touro-affiliated obstetricians as their

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The multi-disciplinary treatment team is comprised of experts with many years of experience working with eating disorder patients. Physicians, nurses, social workers, psychologists, nutritionists, and expressive arts therapists join their collective expertise in addressing the unique and complicated needs of this clinical population. An eclectic approach, including CBT and insight oriented and behavioral psychotherapy are used to treat the psychological underpinnings and the atypical behaviors simultaneously.

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"backup doctors," on call in case of emergencies or indications of elevated risk, most of their births are led by the midwife only, and their cesarean rate is just 9%, about one quarter the state average. Woman to Woman primarily serves patients who are looking for an alternative to medical-model birth, said deJong. They tend to be "well-educated, well-read about birthing options, and they find us. Artists, musicians, alternatively minded people. A lot of medical students, professors, lawyers. We wouldn't mind increasing our clientele and serving people who are outside this demographic," but it is not always clear how to reach expectant mothers from a wider population. When practicing in New Orleans East, however, she did work with a more diverse clientele, and found that these women were also receptive to midwifery, albeit not necessarily for the same reasons.

There are patients who seek out midwifery because of a specific philosophy about birth, "and then patients who just came to us because we were nice!" She laughs, but then makes it clear that for many women, at this vulnerable time in their lives, the warmth associated with midwifery (though not at all limited to midwife-delivered birth) is very important to birthing mothers in general. "I think women would like someone kind. They would like support. They would like to be able to hold the baby right afterward."

While Touro may currently be known as the best place in New Orleans for natural birth, it may soon be facing some strong competition. According to deJong, Ochsner is planning a CABC-certified birth center. Certified by the Commission for the Accreditation of Birth Centers, this type of birth center is specifically and exclusively "for natural births; no continuous fetal monitors, no epidurals, no cesareans. If a patient wanted an epidural, she would be transferred to the labor and delivery unit." Because of its attraction to healthcare and support professionals oriented towards natural birth, such a birth center could become the premier environment for low-risk mothers interested in this kind of birth.

In addition to midwifery by certified nurse midwives, home births are also done in New Orleans, by direct entry midwives. Whereas certified nurse midwives are licensed under the nursing board, direct entry midwives are licensed under their own medical board, in a separate category. The practice is limited, however, since Medicaid does not pay for this type of care; LaMOMS only pays for CNM-based midwifery and obstetrician-based care.

Also limited are options that represent a "middle path" between the polar extremes of "completely natural birth" and "highly technical medical birth," such as labor pain relief by nitrous oxide, a light analgesic gas used throughout the world by midwives, but only in San Francisco and Seattle in the United States. Combining the strengths of natural and medical childbirth and using techniques that do not fit neatly into either camp could provide an alternative that may appeal to mothers whose birth preferences do not fit into either extreme.

All in all, though, regardless of what type of birth they need or want, pregnant mothers in New Orleans have more options than ever before and more tools to help them to achieve a positive birth experience. Several doulas are available here to help women with both natural and medical or surgical births, as are an increasing number of paraprofessionals like massage therapists and hypnotherapists. A variety of childbirth classes are also available. Ochsner offers a Lamaze class, Touro and Tulane offer general childbirth classes, and Touro also offers Balance Born, a course oriented towards "natural, family centered birth and parenting preparation." Private classes include the Bradley Method, Blissborn Birth Hypnosis, the Prepared Childbirth series, Nola Nesting, and Belly Talks, a class held in the Maypop Community Herb Shop that emphasizes herbal remedies in addition to basic childbirth preparation.

Taken together, tools like childbirth education, natural-birth innovations like water birth and acupressure, high-tech medical procedures like cesarean sections and epidural anaesthesia, and public health measures like the Birth Outcomes Initiative are combining to move New Orleans towards the goal of improved birth experiences and outcomes—and happier, healthier mothers with happier, healthier babies. HJNO