Episode 578: Michelle Aristizabal on Natural Birth and Choosing Your Birthing Experience

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Katie: Hello, and welcome to "The Wellness Mama Podcast." I'm Katie from wellnessmama.com and wellnesse.com, that is wellnesse with an E on the end, which is my personal care line. And this episode is all about birth. I'm here with Michelle Aristizabal, who is an OB-GYN in Scottsdale, Arizona. And she's actually written a book called "Natural Labor and Birth: An Evidence-Based Guide to The Natural Birth Plan". She attended Medical School at the University of Arizona and completed her residency training at St. Barnabas Medical Center in New Jersey. She also opened Wound Keepers Maternity Wellness Center in New Jersey, where she personally delivered 2,500 plus babies. And she's a really staunch advocate for better birth outcomes for moms and babies, and extremely well researched in that area. She is an OB who advocates for low intervention, natural birth when possible. And we go into a lot of the different things that go into this today.

We talk about why as a doctor she supports natural birth and the resistance she runs into in doing that. Why doctors and patients often have trouble accomplishing low intervention birth in some certain settings, and what we can do about that. The reason that C-section rate has risen so drastically in the last few decades. Some factors to consider when approaching birth, the real data of low intervention birth, and if it is more dangerous or not. How women can advocate for themselves, and what to do if you have a practitioner who's not working with you. The factors we can do to increase our chance of a natural birth, and the real stats on safety of home birth versus hospital birth. She's so knowledgeable. This was such a fun conversation. I can't

wait to jump in. So, without further ado, let's join Michelle. Michelle, welcome. And thanks so much for being here.

Michelle: Thank you. I'm happy to be here.

Katie: I'm really excited to get to chat about birth and natural birth today. I haven't talked about this on this podcast in a while, and it's a topic that is very close to my heart personally, having had six kids. And I know you have a whole lot of experience in this realm, and we're gonna get to go deep on a lot of topics that I think are extremely relevant, especially to pregnant moms.

And to start off kind of broad, you are coming from the doctor side of this. And I would love to hear some of your perspective on that because I know, for me, I have had kind of the gamut of birth experiences. But my first being, I wanted to have a natural birth and ran into a lot of resistance I did not expect in the hospital once I got there. And I've always also thought that doctors, you don't go through all of those years of school without having a true desire to help people. And I've often wondered if doctors sometimes hit as much frustration as patients do with some of these options. So, start off kind of broad, maybe give us your perspective on the doctor's side of natural birth, especially in a hospital setting, and what kind of resistance you run into there.

Michelle: So, I initially attended medical school at a pretty holistic medical school, the University of Arizona. They had an integrative medicine program at their medical school, and they definitely approached labor and delivery, I felt like, you know, a little kinder and gentler and with a little more of a natural focus than I think I certainly observed later on in my training. But once I went into training, I basically, in my specialty training in obstetrics, received no training in any low intervention, natural birth techniques. So, this is really an area that I entered into after my training, really because I saw a need that this is something that mothers wanted. And I didn't really have the tools to offer it to them, so I began learning about it.

But as to why it's not available, I think, really, there's a lot of different things going on. One, most doctors complete their residency in big tertiary care centers that are high risk with a lot of high-risk deliveries going on, so they simply just don't have the exposure to what normal physiologic birth can look like unless there's a midwifery program or an obstetrician who's delivering at that hospital. But also just our healthcare systems don't really make this very easy either, the way offices are structured, patient loads are structured, or just even our reimbursement from insurance companies are structured.

Physicians, which is 97% of who's delivering babies, are delivering a large volume of patients. And there's definitely a perception that natural birth takes more time than a very medicalized birth, which hasn't been my experience doing it, but there's definitely that perception of, "If I support this mom's birth plan, then she's just gonna labor in the hospital for days and nobody has time for that." So, some of it is misperception on the part of the obstetricians.

I think there's also a misperception that somehow, which...has a crazy thing for me that somehow natural birth is more dangerous or that physicians are more susceptible to litigation suits if they support moms who are having natural births. So, just a lot of different things that I think are going on that are impacting this resistance from both providers and hospitals and making it difficult for mom to find those options.

Katie: Yeah. I think you're right. There's a lot that goes into that. I love that you used the term "low intervention." I think that's a great term because natural birth, I think can encompass a lot of things, but also it can be confusing of what that means. And I think low intervention sums it up well. And also acknowledging that everyone's, I hope, going into a birth experience and wanting the best outcome for mom and baby. At the end of the day, that's everyone in the room's goal is healthy mom, healthy baby. And I think that maybe there's just often differences. And to your point, probably a lot of them does come from insurance companies or the liability team at the hospital on what they consider the safest option for the mom and the baby.

But let's talk about some of the reasons that women might want to consider a lower intervention birth, because people might be aware, the statistics are not great in the U.S. as far as maternal mortality, infant mortality, and birth complication, C-section rate. For being as advanced of a country as we are, it's actually pretty abysmal some of the rates related to birth outcomes.

So, maybe walk us through just an overview of some of the things women could consider as options when they're approaching a birth experience to be lower intervention and why they'd be worth considering.

Michelle: So, as you mentioned, low intervention takes kind of a wide gamut. I have patients who come to me, and their definition of low intervention is just, I don't want a C-section. Whereas I have other moms where their definition of natural or low intervention is no medications. Some moms, that means not birthing in a hospital and having an out-of-hospital birth. So, there's definitely a wide range. But I think some of the reasons that mothers are looking for other options and not necessarily looking for the standard approach is, one, fear of needing a surgical birth. C-Section rates have been pretty steady at 32% for about the last 20 years.

I think most women sort of have an intuitive sense that one-third of women shouldn't need surgery to deliver their babies. So, that C-section rate in our country really changed in a very short time period. It changed from the early 1990s to the early 2000s, roughly 10-year timeframe, we went from roughly 18 to 20% up to that 32%. So, it wasn't like this was a gradual thing. It really was pretty abrupt. And when we look at those causes, you can't just account that to demographics or some Mom related effect or even some difference in the training of our care providers. It's clearly something in the way we're taking care of women.

So, I think, number one, people are looking for options that don't involve them having surgery so they can get started with their motherhood in a better way. I think mothers are looking for more choices. I think people have just become more aware that they do have choices in healthcare. And so they're more conscious about what they're putting in their body. They wanna know what that medication is. If we're going to be doing an induction, they wanna know what meds they're getting and why. So, it's not just sort of that automatic, "Oh, the doctor told me, so I'm gonna do that." And I think that goes in all areas of medicine, but especially obstetrics.

And then I think people really have to value just the experience of childbirth itself and recognize that there is something really important there and something that's not just a physical process, but something that's really emotional and spiritual and have begun to give that a little more of the honoring it the way that it should be.

Katie: Yeah. I know I've heard from many women and myself had those experiences where birth is such a profound experience that shows you maybe parts of yourself that you didn't know were there. Or I've heard it said, kinda, birth is your ultimate reality. And I feel like many women emerge from birth, especially when they are able to have the birth experience they want, with almost this, like, "Oh, wow, I can do anything," mentality.

Michelle: Yeah.

Katie: Because you get to face the intensity of it and come out the other side with the best prize ever. And I think it's a beautiful experience. And I love that you also brought up that there's this conception, that natural birth can be more dangerous. And I would love for us to tackle maybe some data. Is that actually true? Are there things that make that more or less true that are within a woman's control? And I've also always said, I think the best outcomes in medicine happen across the board, not just in obstetrics but when you have an informed patient who actually has done their research and who's making informed choices, working with a practitioner who's knowledgeable, who supports them to the degree that it's possible and safe. But where does that misconception come from, that natural birth can be more dangerous? And is that actually true?

Michelle: I think that misconception comes from the idea that if a mom is declining some interventions, that she's gonna be declining all interventions and including interventions that have been shown to improve safety outcomes. So, I think that's one of the misperceptions, because I don't have a single patient who is like, "I don't want any modern medicine." I think most people want some modern medicine, but also, I think it comes from some of the over-publicized horror stories of maybe home births gone wrong or situations where maybe patients didn't have providers that did a good job of counseling them and informing them. And they didn't really have the tools to make good decisions. And so maybe they did decline intervention that may have helped them and may have improved their outcome for their birth. So...

And then just simple misunderstanding. Really a common example that I bring up to providers that I talk to is just fetal monitoring. We don't have fantastic evidence that fetal monitoring alone improves outcome for low-risk mothers. We have data that it improves outcomes for high-risk mothers, but for low-risk mothers, we don't have great data that says that it's any better than just listening to the heartbeat at specific times during the labor pattern. And yet there's physicians who believe that if that baby comes off the monitor for a second, that something terrible and horrible is going to happen and that it's not safe, it's dangerous to be off the monitor. And so there's a lot of restricting of ambulation from that or restricting access to hydrotherapy really because of that fear, and they're not understanding the safety of these different techniques.

Katie: Yeah, I think that makes a lot of sense. And I think...like I said, I think the best outcomes happen when you have informed patients working with doctors who are supportive and also able to help educate the patients. And as a doula myself, I've very much been in favor of moms being able to choose whatever their birth experience that they want. Even, I know moms who have chosen, for their own reasons, C-sections without even needing them, necessarily. And I am fully in support of that. But I think also, especially when it comes to choosing a lower intervention birth, that's when women tend to maybe run into more resistance. So, what are some ways that women can advocate for themselves and work with their doctors?

Because I know also I've heard doctors get frustrated from patients who are trying to advocate, but maybe not very effectively. And the doctor feels like the woman's kind of being hard to work with as well. What are some ways we can effectively advocate for ourselves?

Michelle: Well, I somewhat blame the doctor more in that situation than I blame the patient. So, I hate to make the patient look like there's something magical that they need to be doing to effectively communicate with the physician. Like this is our job, is to figure out how to effectively communicate with the patients and hear what's important to them and hear what their priorities are. We talk about shared decision-making in medicine. And that's a huge piece of it, is taking that time to really listen to what your patient's saying, put your own ego aside. My personal feeling of this sort of resistance to hearing, especially what women have to say in labor comes from a rather paternalistic history of obstetrics of, "We know what's best for you, and don't tell me, who's trained for 12-plus years to do this job, what's the safest thing in labor."

But just because you might know "the safest" doesn't mean you necessarily know what's the right decision for your patient, because there's many, many different options. There's very few scenarios where there's truly only one option of care. And having enough humbleness to recognize that and recognize that maybe what you would choose for that woman may not be what she would choose for herself and that you could still offer her a safe outcome, that is something that she feels comfortable with, that's the art of medicine that you're supposed to be doing as a provider.

So, I really think it's just creating space for patients. So, I don't put a ton of pressure on the patient for that. I really think if a woman's not finding space with her doctor or her midwife for that conversation and feeling like she is...that the physician is resisting that conversation or the midwife's resisting that conversation, then

that is one of those few times that I'm like, "Yeah, maybe you really should have a new provider." Because you should be to have conversations. At the bare minimum, you should be to talk about your options with your provider. A little bit of soapbox.

Katie: I think language, to your point, is so important when it comes to that. And I remember my first birth was with a doctor in a hospital. And then I was with midwives in a hospital. And I remember the difference in having been through a birth with a doctor and then when I got to the midwives, asking questions, and I would be like, "Well, will you let me do this? And will I be allowed to do this?" And the mid-midwife telling me, "It's your birth. You're don't need to ask my permission. I'm not allowing you, you're paying me. And I'm gonna inform you if I think something's not safe, but it's, at the end of the day, your choice." And that was such a profound moment for me that really helped me advocate for myself later on, especially my last two were both breech. And with my number 5 at my 37-week appointment was told, "We're not gonna let you deliver naturally."

And I said, "Well, then you're fired." And I walked out of the... And then I was like, "Oh no, I've gotta find someone to help catch this baby pretty quick." But it ended up working out really, really well. And I think you're right. It makes sense. Doctors go through a lot of education to get to that point. And certainly not to diminish that at all, they do have very specific knowledge that's amazingly helpful, but I also very much believe in a woman's knowledge of her own body. And I've seen it play out as a doula, many times. Like a mom who is there with her fifth baby, and they told her she was 4 centimeters and then 10 minutes later, she's like, "I'm pushing." And they're like, "No, honey, you're not pushing." And she starts doing the like, "Eeh." And I'm like, "She knows her body. She's pushing, whether you think she should be or not. She is."

But let's maybe go through the checklist of some of the common ones that come up, because I know, like you mentioned, monitoring for instance, in a hospital being very common practice and maybe not having as much evidence behind it as we think. But that's one thing that often keeps women in a bed, not moving around, which can also have an effect on the outcome of labor. If women aren't allowed to move around, that can change labor progression, same thing with, like, women are often told they can't eat or drink in a hospital setting.

Maybe take us through some of those common practices and if women are...like, for instance, I've advocated for myself in a hospital and said, "Thank you for your advice. I'm gonna choose to eat. I know that there's a low risk of me aspirating this if I did need to be put under anesthesia, and I am gonna choose to nourish myself so that I can hopefully have a natural birth." But what are some of those areas that women actually maybe have a choice, but maybe don't know they have a choice if they're just being told in a hospital setting, "You're not allowed to do this"?

Michelle: Yeah. So, another common one is IVs. So, a lot of moms think when they come in, they have to have an IV placed automatically. And they may not know that they can decline that or they can choose to have a Heplock IV instead. Other things would be the ability just to get out of bed and move and that they don't

necessarily have to labor in the bed, that they can deliver in other positions, that they can, as you mentioned, eat, drink, and that the risks associated with that are very, very low. And then I think some of the bigger things like C-sections, inductions, a lot of times are presented to women as if there is no choice as just, "We are going to do this." And a lot of women don't realize that that is just a discussion that they can have with their provider, particularly like if they've had a previous C-section, it's a discussion they can have of whether or not they want another C-section.

Katie: Yeah. I've had that experience as well. I never in my head thought I would have a C-section because I was very into natural birth. And even I would skip over the chapters in birth books about C-sections because I was like, "I'm never gonna have one of those." And then my third, I had placenta previa that, despite ultrasounds, was not caught, and ended up with an emergency C-section, and I realized I had no knowledge related to C-sections because I had just skipped over that entire section of everything I'd ever read about pregnancy. And then after that was told, "Well, now you have to keep having C-sections, and questioned it and found a provider who was like, "Absolutely not. You had two vaginal births pre-C-section. There's absolutely no reason you can't be back from here on out."

But I think a lot of women are told that, like no, once a C-section always a C-section, which, at least from my research after, the data doesn't actually support that at all. Like, short of certain circumstances that make it more dangerous, it actually seems like it's safer on average for most women to have a V birth versus another C-section.

Michelle: Yeah. After a mom's had a C-section the best outcomes for Mom and baby are for a vaginal delivery.

Katie: And I know that there's a lot of reasons for that as well. There's a lot of factors that go into it. I did a lot of research and was fascinated by the microbial aspect of birth and that microbiota transfer. And I feel like the more we learn about gut health, we're learning a lot of that seeding happens during the birth process. So, a C-section of babies missing that window, which certainly there are things you can do, like swabbing to help create that when you do need a C-section. But can you maybe explain that microbial transfer process that happens during birth that you might not have if you have a C-section unless you would intentionally do that?

Michelle: So, when a mom has a vaginal delivery and the baby's coming down through the vaginal canal, it's passing through that vaginal flora where we all have bacteria in our gut. And that bacteria is a complex combination of a bunch of different flora lines that you can't necessarily just make up after the fact. And we know that by the baby passing through that vaginal canal, and it's not just like that getting on their skin, it's actually the baby swallowing that fluid that has that flora in it. That is part of the process. So, like while we can try to do some things after the fact to help the cause like with the swabbing and that sort of thing, it's not the same thing as that baby spending an hour or two in the vaginal canal swallowing the fluid during the birth process that is rich with that flora and that flora getting deep into the gut.

So, I often tell my patients, "No matter what we talk about, we're nowhere near as good as nature at creating the situations of the labor process." Yes, we can make contractions with Pitocin, but they're not the same contractions as your natural oxytocin produces. Yes, we can open up a cervix and get it ripened, but we're not nearly as good at doing that as you are. We can help you deliver a baby in different positions when you're on your back, but you're probably going to do a lot better job at getting the baby out if you're able to be in positions that's right for you and for your baby and how that baby's oriented in your pelvis. So, this is just, I think another example of, nature often knows best. Yes, sometimes there are good indications to do a C-section and lifesaving indications for doing a C-section. But if they're not truly necessary, then we're missing out on a whole lot of good things that we can't really make up for after the fact.

Katie: And sometimes you often hear the term cascade of interventions and how certain things can lead to further intervention because of some of those factors you just mentioned, if women aren't moving, maybe can have a harder time moving down in the pelvis, etc. If women aren't eating, they can get tired and their fatigue can actually be the reason that they're not progressing, things like that. So, obviously with the note that everything is personalized, that every labor progresses differently, what are some of the factors that women can do that will help put those odds in their favor when it comes to having a lower intervention birth?

Michelle: So, I always tell my patients that the foundation of a low intervention birth actually starts during pregnancy because the number one predictor of whether or not a patient is going to have a low intervention birth is whether or not she's able to start labor spontaneously versus have an induction. 60% of first-time moms in our country are induced, which is just crazy. And once we do an induction, basically so many components of a low intervention birth are immediately put out of the window because of just the cascade of interventions that we have to do to make an induction safe. And why do I say that the foundations of a spontaneous labor start in pregnancy? Because many of the indications for induction are lighter. So, it's things like diabetes, hypertension, it's pregnancies going late, things like that.

So, I really encourage patients to really focus on a good well-rounded diet in pregnancy that reduces the risk of diabetes, that helps promote good gut bacteria and vaginal flora, which, again, we don't have tons of evidence for, but a growing body evidence to say that things like premature rupture membranes and infections that could ascend up to the uterus. Exercise we know reduces excess weight gain in pregnancy. It helps keep a mother strong and gives her the tools to stay mobile both throughout her pregnancy and during her labor. So, again, creating that good foundation of fetal positioning and good foundation of pelvic relaxation and openness to help facilitate her labor process. So, I think that's the first thing that a mom can do. And then second thing is just really good training for her labor. I think of labor and delivery like climbing a mountain or a marathon.

There are definitely people who are like, "I'm gonna go do that today." And they're successful, but that's not the majority of people. If you don't train and you don't prepare, you're not gonna be very successful at something that's so physically demanding and so mentally demanding. And so, really, doing some intense thorough preparation for that labor and delivery process, again, is gonna set the foundation that you don't get that epidural too early or need other medications because once you choose to get an epidural, now you need

continuous monitoring. Now you need IV fluids, you are restricted to the bed. So, just to your point, one intervention tends to beget another. We see a really high association between epidural use and Pitocin in both directions. Pitocin leads to epidurals and epidurals often lead to Pitocin.

So, trying to set the stage for minimizing those needs for those interventions is the best moms can do. And we see that pattern for moms who prepare that way and come into labor that way in lower intervention rates, lower C-section rates, and just better birth outcomes and more moms who feel better about their birth process as well.

Katie: Yeah. And I'd love to also touch on the home birth versus hospital births debate. I actually was part of a team that helped lobby to make homebirth legal in Kentucky, where I used to live, which... is ironic to me that Kentucky of all places home birth was illegal for a long time. And I remember sitting in one of those committee meetings with the medical committee and one of the OBs, male OB who's probably in his 60s on the committee and him saying women can't be trusted to make these decisions. And I think that unfortunately there are people within the industry that have that prevailing attitude. But those people that we encountered there, they certainly had the mindset that home birth was gonna be very dangerous and babies were gonna die all over the place.

And certainly the data I've seen doesn't seem to support that, but I know that many women have some fear around the idea of home birth because they have heard a lot of things like that. So, let's talk about home birth versus hospital birth and what the statistics say, what you know as a provider, and what advice you'd give women there.

Michelle: Yeah. So, the home birth versus hospital birth is a challenging question and a challenging debate in states because we don't have a standardized system in the U.S. So, there's a lot of variation in one, the care providers and also the systems for integrating moms who may need a higher level of care during a home birth back into the hospital system. So, we don't see the same rates in the United States for home birth in terms of safety as we see, for example, in Europe where home birth is very well done. So, what we know is that home birth can be very safe with well-trained providers and with providers that are integrated into the medical system, meaning that there's a way for those providers to reach out to higher level of care if they need to, and a way for those providers to facilitate ready transferring to hospital if that’s necessary.

So, I think what I think the data shows when we look at the U.S. data versus other countries, is that it's not about the location, it's about the teams and the systems that are in place to take care of mom's side and provide that care. And we sort of prove that with our birth centers, because they're kind of a middle-of-the-road. So, our birth centers in the United States have very comparable outcomes to hospital. And why? Because in order be advised, the providers in your centers have to have certain standards of training. There has to be integration, for example, in a birth center, there needs to be some collaboration with an obstetrician. There needs to be some plan for transfer to hospital. And we see very good rates with our birth centers. So, we know home birth can be equally safe, because there's not a substantial difference between a

home birth and a birth center birth. In terms of the facilities, it's just that connection to a higher level of care if it's necessary. And making sure that the patients who are having home births are risk appropriate for those home births.

So, it's a really interesting problem. Unfortunately, the American Board of Obstetrics and Gynecology has come down really hard against home births. And made some really strong statements against home birth. And that has almost led to an inability to look for solutions to make home birth better and safer in this country despite the large number of patients who want home birth and want that as an option. So, it's kind of similar to what often happens in hospitals, like we don't feel comfortable with this. We feel like this isn't the best option, and so we're just gonna say no instead of looking for solutions to offer a solution to make a way. So, it's really short sighted and quite literally throwing the baby out with the bathwater, in my opinion.

Katie: Yeah, I recently had a conversation with my cousin about this, actually. She lives in London and she had almost the exact opposite of her first birth experience where home birth was encouraged, and you're given a whole team of midwives who come to your house, they do a ton of education and support. And they do talk to them about nutrition and movement and all these factors. And they do screen them as well. And if there's a reason they can't deliver at home, they have appropriate care in hospitals as well. But the standard of care, the preferred care is home birth, which is like you said, a huge drastic difference from here. And their rates in home birth are very good because that's what they support and that's what the research is around.

And you used the term high risk, which I think is another important one to define. Because I think many women are told they're high risk and maybe not even given a whole lot of explanation as to why. And there's a whole lot of things that seem to fall under this umbrella of high risk, whether it be being over 35 or multiples or having a high blood pressure. There's so many things that seem to fit under that umbrella. What does it actually mean to be high risk? And are we overusing that term? And if a mother is high risk, is she automatically excluded from these other options of lower intervention birth?

Michelle: So, high risk is definitely an overutilized term and it's also, as you mentioned, a very poorly defined term. So, there are certainly conditions that put a mother at larger risk during pregnancy that if everything goes well, may not impact her labor at all and she may be actually fairly low risk for labor, but yet still for a lot of women restrict their options. There's conditions that may not be at risk. A mom may not have a significant risk during the pregnancy and suddenly develops risk during the labor. So, I think just this universal, put a stamp on a woman's head saying you're high risk and then use that to mandate inductions, mandate C-sections, and not offer her choices is unfortunately actually leading a lot of women who probably would be more appropriate to deliver in hospital under either the caregiver look for birthing options outside of hospital, because they're just not being offered choices in hospital that are low intervention, which is a real shame.

So, in terms of things that are legitimately high risk, certainly moms who've had a history of a previous poor outcome in a previous pregnancy. So, something like previous premature delivery, a previous still birth, a history of significant preeclampsia or low birth weight or something that indicated significant what we'd call placental insufficiency, where the placenta wasn't growing and feeding the baby the way that it should have, those would all be significant risk factors for the subsequent pregnancy. Or if mom has a significant medical condition, some sort of heart disease, significant asthma, there's a very long list. And those are things that we know because it's from her history. And then there's things that develop during the pregnancy that can be higher risk for mom. Things like gestational diabetes, hypertension, and those usually fall more in the moderate risk categories.

So, yes, there are higher risk for certain complications, but most moms will go on to have healthy births and healthy outcomes with those condition. But a lot of moms with even more of those moderate risk conditions are encouraged to have C-sections, encouraged to have inductions pretty early on and not necessarily given a lot of choice or a lot of alternative to managing those conditions.

Katie: So, how do you think we, as a country, can start to address some of these problems? What's needed to actually bring more of this level of care and low intervention birth into hospitals so that women do have those options? How do we actually change the standard of care there?

Michelle: So, it's challenging but I definitely think one of the ways we start doing it is by encouraging more education in this area, both among obstetricians and nursing staff. And I think that's starting to happen a little bit as hospitals are realizing they need to lower their C-section rates and improve some of these outcomes, especially as insurers are beginning to tie reimbursements to lower C-section rates. We're seeing a renewed

interest in looking at different ways we can lower C-section rates. But I think it's more than just teaching physicians how to use a peanut ball, for example. I think it's also about changing our philosophy towards birth and really gaining exposure to a more holistic viewpoint towards pregnancy and towards labor and delivery.

And I really think that's just with exposure to a more midwifery mindset towards care and that takes credentialing midwives in hospitals, and having an active midwifery program in hospitals, including these big level three hospitals where the majority of OB/GYN residents are training so that they can see no, this model of care is safe, this model of care often produces better outcomes than we're producing. And they begin to see it done a different way and see that as a normal for women so that it doesn't just seem like this strange thing that's done on the fringes of the medical system.

Katie: And you're so passionate about this, you actually have written a book about natural birth. And I would love for you to talk about that, what your goal is with the book. I got to check it out and it's awesome, but I think it solves a lot of these problems we're talking about because it's the education and you can speak to both sides and to that physician side that's so important as well.

Michelle: Yeah. So, I wrote this book in response to actually a lot of pushback that I received in my various hospitals in supporting moms who had natural birth plans. I would have moms come in with their birth plans and wanting to ambulate, want to use the showers, and those sorts of things. And just nurses not feeling comfortable, some of the other doctors not feeling comfortable and they'd be like, "Well, where's the evidence that shows this is safe?" I'd go and I'd pull all the research and I be like, "Here, here's the evidence, here's the research articles." And so, I really came to realize that there was sort of a lack of one resource to show the evidence for all the various points of the natural birth plan. So, that was the point of the book I wrote, a guide, so to speak to that natural birth plan, that really showed the evidence and really attempted to explain both to patients and to their providers of, hey, why is this thing that a woman's asking for, why does it matter to her?

Why is it a good thing? If there's any concerns about it, what are they? And, is it reasonable to offer? Should we be supporting it? And there really isn't a whole heck of a lot in the natural birth plan, there really... The only thing that I could say there was not evidence for was I think placental encapsulation. That's the only thing that I didn't find any evidence in support of, but pretty much every other thing there was solid support for in our own medical literature. So, I think it was just a hope to be a wakeup call and to give a tool to patients who wanted more of a scientific understanding of these things and wanted to have some scientific tools to sort of go to their providers and say, "Hey, yeah, this is legit. This has evidence. This is the evidence. I am informed, and this is what I'm doing. You don't get to not allow me." So...

Katie: Yeah, that's an important phrase. You don't get to not allow me. And I often ask what are things that people don't know or understand about your particular area of expertise and your answers to this were so good. I know we've touched a little bit on some of them, but maybe walk us through any other kind of misconceptions or things people don't know and understand when it comes to birth.

Michelle: Oh gosh, I'm now forgetting what my answers were. But no, I think one of the big misperception is what I alluded to that somehow that the idea that a controlled or medicalized birth is safer. That's a misperception in the medical community. I always lost my mind in one of my previous hospitals, because they had a longer consent form to use the labor tub than the consent form to be induced and have a C-section, which was just crazy to me. I'm like, "Surely surgery is higher risk than a bathtub." But just shows where their priorities were. But I think another misperception for women is that they don't have a say, that they somehow give up their autonomy when they become pregnant. Which, yes, I know in today's climate, maybe there's some people who feel that way. But on labor and delivery, you can consent, you have informed consent and you have the right to informed consent, and you deserve that right to make these decisions.

And a woman's labor and delivery experience matters. And it really is the foundation of her motherhood. I use that phrase a lot, it's a couple's first act of parenting and it matters how it starts and it's important. So, we need to value it and we need a higher bar than just, "Did everyone make it out alive?" We need a higher bar than that.

Katie: I completely agree. I know many women have birth experiences that they then later have to work through because it does really profoundly affect you. And it can have a negative effect on the mom as well. And that's an important aspect of motherhood is mom's mental health and mom's ability to show up as a mom. So, I love that you are shining light on this and you're bringing awareness to this and educating from a physician's perspective, I think that's gonna really help to change the landscape. And I think that combined with women educating themselves and making informed choices and being able to stand up for themselves and advocate for themselves before, during, and after birth, I'm hopeful that we'll start to see some of these statistics change.

And as we get to the end of our time, another question I love to ask is if there is a book or number of books that have had a profound impact on you, and if so, what they are and why?

Michelle: So, yeah, I'm an English lit major, so I read lots and lots of books, and lots of books are important to me personally, but professionally one that had a really big influence on me, which I read very soon after I completed residency was Jennifer Block's book, "Pushed". Which, if you haven't read it, is just a really, really amazing overview of what's going on in the American maternity system. And I feel like while some obstetricians have criticized us being biased or antimedical, I didn't see it that way. I actually saw it as a very unbiased, just reflective view at this very difficult situation where everyone is pushed, and everyone's at the mercy of this system that really does need to be rethought and that we really do need to reevaluate so that we can provide better care to women. So, I thought it was a beautiful and very thorough look at that and really gave me a huge amount of inspiration to try to do maternity care different in my own practice.

And interestingly, she had rotated at the hospital where I did my residency, she shadowed and interviewed doctors, and that was the hospital she talked about in her book. And I had gone through four years of residency and no one mentioned that and I was just dumbfounded. And I'm like, "How is it that we're like featured in a book about maternity care that has sold millions of copies and no one has discussed it?" I just couldn't believe it. It was crazy.

Katie: Oh, wow. Well, I echo that recommendation of that book. That was, I think I read when I was pregnant with my second. And it definitely helped me think through things a lot differently. She does a great job like you do of shedding light on the actual reality of what's going on and how women can make better choices. And I'm very grateful for people like both of you who are doing this work and day to day helping so many women. I'm very, very grateful for your time. Thank you so much for being here. I know how busy you are and I'm so glad we got to chat.

Michelle: Absolutely. I appreciate it.

Katie: And thanks to all of you for listening and joining us today for sharing your most valuable resource, your time, your energy and attention with us today. We're both so grateful you did and I hope you will join me on the next episode of The Wellness Mama Podcast.

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