With the recent doubling down of the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) urging breastfeeding at all costs despite no country meeting their standards, has the latest reversal of the "normal birth" campaign in the United Kingdom (UK) due to deleterious outcomes taught us anything? Value-laden ideology should not drive health policy.

Recently, I wrote about the misguided, alarmist efforts of the self-proclaimed Global Breastfeeding Collective composed of the WHO and UNICEF (see here [2]). As a result of every country in the world not meeting the "breastfeeding standards" they set forth, instead of partaking in some self-reflection as to why there might be flaws in their idealized metric, the group amplified its call for dramatic action on all economic, political, environmental and social fronts.

They made a political move, not a health one. They classified the issue as “urgent” for policymakers and in need of exorbitant funding. Begging the question: Is demanding hefty sums to mandate societal shifts even solving a problem in need of solving?

This is not uncommon and such policies do not optimally serve women and families—in fact, they can do harm. In the UK, due to deaths along with substantial maternal pelvic floor damage from increased forceps use employed to facilitate vaginal deliveries as well as other adverse effects, the twelve-year at all costs “natural” or “normal” birth campaign by the Royal College of Midwives has been reversed. This will be addressed shortly.

Among the Global Breastfeeding Collective’s messaging [2] is championing breastfeeding in “exceptionally difficult circumstances” with “families suffering the consequences of complex emergencies” and being the solution to infant deaths. Entirely neglecting discussion of pathological conditions that can hamper the ability for a woman to breastfeed, as one example, they convey an
inaccurate picture politicizing the reality and portray alternative modes of nutrition as shortchanging your baby by predisposing him to disease and an inferior start to life. The language borders on the coercive and preys on the vulnerabilities and fears of parents, especially new ones.

This is irresponsible and disheartening. It contributes to feelings of failure and adds unnecessary anxiety and torment to what should be a joyous experience. Beyond that, when taken to extremes, doing so can imperil an infant and mother’s well-being. There is no dispute that breast milk is the gold standard for a baby, but formula can be good enough and is not evil. We are fortunate to live in a time where reasonable substitutes exist and can place an infant on a thriving trajectory.

This wasn’t always the case. We so quickly forget.

The entire clinical picture, medical history and comprehensive physical examinations of mother and infant play extraordinary roles in making an informed, correct decision regarding proper feeding and a host of medical conditions. It is not one-size-fits-all. This choice is to be made in consultation with their health care provider who is actively participating in their care and privy to any and all dynamic changes in clinical course. There are instances where even the word “choice” does not precisely convey the circumstances.

The goal should be optimal physical and mental health of the mother and the baby. When breastfeeding at all costs as an idealized metric serves to expedite a mother’s postpartum psychosis or guilts one undergoing chemotherapy for breast cancer, such policies miss the point and violate the fundamental tenets of the medical profession to first do no harm.

We are fortunate to live in a time when modern medical advances exist. For, they have single-handedly improved survival. Our memories are altogether too short as to how high maternal and infant mortality rates used to be due to lack of sanitation, the pre-antibiotic era and evolution of our understanding of proper infection control. Childbirth used to be an even riskier proposition.

The challenges of developed countries are vastly different than those lacking such formed public health infrastructures. Nuanced policies should reflect such disparate nations when it comes to issues of medical care and implementation. Wide brushes are poor policy. (See Top Cause of Death: Geography [3] and Committee To Reduce Infection Deaths Hosts Forum Of Public Health Leaders [4]).

In the United States, if we partially informed patients it would be egregious and considered negligent. Informed consent is vital to a functioning, therapeutic and successful doctor-patient relationship. It establishes trust and encourages patient autonomy while maintaining a synergy that supports the best interest of the patient. Depending on the case, there can be risks and benefits to breastfeeding. More often the benefits outweigh the risks which is a remarkable consideration about breastfeeding and why it is such a wonderful option. But, not always. And that too needs to be a part of the conversation.

Apparently, the “normal birth” movement campaign in the UK— started in 2005 by the Royal College of Midwives—has recently been ended due to bad outcomes. It involved an ideological, value-laden undercurrent that emphasized the benefits of vaginal or physiologic birth without any
discussion of risks. An investigation into a number of unnecessary deaths and serious incidents led to the Morecambe Bay Trust which among other poor reports [5] (demonstrating significant variability of midwife training etc.) yielded this reversal.

That particular inquiry revealed scandal. Midwives were found to urge normal birth “at all costs” and perpetuate dangerous deliveries. According to The Guardian [6], “inquiry into deaths of 11 babies and a mother at Furness hospital in Cumbria says midwives were so cavalier they were nicknamed “the musketeers.”” Described as a “lethal mix” of failures at all levels, the independent report can be found here [7]. The findings demonstrated a groupthink denial, collusion and “distortion of the truth” which served to put women and babies at further risk as well as a fundamental lack of knowledge of shifting clinical status, early detection and patient safety. A growing number of publications [5] showing liability and poor decision-making added to this mix over time and contributed to public distrust.

As I always say in medicine, good information saves lives while bad information can end them. Value-laden ideology has no place in healthcare. Pregnant women should know the risks and benefits of the procedures or therapies they endure. Breastfeeding and vaginal birth at all costs can absolutely do harm, sometimes irreparably. Fortunately, in the majority of instances breast milk and vaginal births are the superior means of supporting a healthy mother and baby. In childbirth specifically, when the clinical course is uneventful, this mode will likely be in the short- and long-term best interest of the mom and baby. However, when adverse events do take place, swift informed decisions need to be made on medical interventions that could mean the difference between life or death, transient or chronic disease and disability.

Withholding obstetric care or physician involvement in 2017 or being paternalistic in judging use of epidurals or Cesarean sections (C-sections) is completely unacceptable. Each intervention or lack thereof can have implications with some better than others—all should be openly addressed with expectant mothers. Routinely, these often non-choices occur amidst crises or —if lucky enough —allow for crisis avoidance. Though the UK investigation(s) was a blow to midwives, in general, it should be noted that bad actors abound in any field. Such a circumstance should not necessarily malign an entire community. Midwives can play a wonderful role in healthcare delivery. They can -- as long as appropriately educationally primed and well-supervised -- provide an invaluable service in low risk populations desiring less interventions in hospital environments where an operating room is nearby and an obstetrician is at the ready.

Birth is an unpredictable, often traumatic journey. This notion that delivering in a hospital or facility with modern medical capabilities is mutually exclusive with a natural childbirth is unfounded. Obstetricians as a matter of routine explore this and other options with their eligible patients. When maternal or fetal health is at grave risk, then discussions must evolve to accommodate these considerations. And do so expeditiously, unlike the egregious practices that took place in the UK.

At All Costs philosophies in these realms don’t reflect medical understanding, rather are virtue-signaling which is fundamentally at odds with superior heath care delivery. Appreciating the risks and benefits of implementing or holding off on interventions is a discussion for health providers and their patients. External commentary on personal decisions without all of the facts is ill-advised.
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