(introductory music)

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MARYN: Welcome to Indie Birth's series of podcasts here on iTunes, *Taking Back Birth*. Hi, everyone. Maryn here with a really special couple of interviews or chats here on my regular podcast. I wanted to do a couple of getting to know yous with some of our speakers and teachers for our upcoming conference, the Indie Birth midwifery conference in Sedona in January 2016. So for those of you that don't know, this conference has a very specific and intention. We are intending to combine the art and science of midwifery as we see it today. So combining what we know traditionally, all the knowledge that's in our past as midwives along with the research and the technology and everything that we have at our disposal now and creating what we're calling a new midwifery where we're really, really responsible to the mother and family. And we do the best we can to honor her.

So with that, my very first guest on this series is not a midwife. But it's almost better. I want to welcome Dr. Stuart Fischbein to this podcast. So excited to have him here. If you don't know, Dr. Stu is a practicing obstetrician in the LA area. And he's not just any OB. So we're going to have a really fun time just getting to know him and getting all of you midwives excited about meeting him face to face and hearing what he has to offer. So I am so excited to have somebody so knowledgeable and a doctor. I think most midwives could count on one hand if not—if that—doctors that really respect birth that really respect birthing women, and really respect midwifery. And so Dr. Stu was one of those very few, rare birds out there. And whether it's offering women choices, VBACs, twins, breech, specializing in home births, which, of course, is the most unique thing, we're just so excited. So welcome Dr. Stu. Thank you so much for talking with me today.

DR. STU: Thanks for that introduction. It's a pleasure to speak whenever I can on the topics that you are looking forward to bringing to the Sedona area in January. I'm just excited about coming and meeting all your colleagues and being in Sedona. It's one of my favorite places. I haven't been there in about 10 years. And I'm looking forward to seeing everybody in January.

MARYN: Oh, yeah. Us too. And it's changed a lot here in 10 years. So it'll be fun to see what you think too.

DR. STU: Yeah. I'm sort of glad you guys aren't in North Dakota. Because it is appealing to go to Sedona in January and not necessarily North Dakota. So this is great.

MARYN: Certainly. Yeah. And definitely no accident. The weather will be awesome. And yeah. The views are spectacular. All the things Sedona is known for. So this is just another great thing to have someone like you come. And, again, not a midwife. But that's wonderful. I just really have been wanting to ask you where did you first realize you had this connection to the midwifery model of care. How did you identify with that as something that made sense to you?

DR. STU: Okay. Well, what I'd like to do is make sure that if your listeners don't know who I am or anything like that that they can put it on pause for a second. And they can go to my website, birthinginstincts.com. And they can get a little bit more insight into the sort of practice that I have and a little bit of my philosophy. But my—I came out of residency. I'm from Minnesota. I went to University of Minnesota Medical School. And thus my rather aversion to cold weather at this point in my life. I've been living in California now for 30 years. So—and then I did my residency here in Los Angeles at Cedar Sinai Medical Center where I had the good fortune of being trained in an era where we were still exposed to pretty obstetrics in its raw form where we got to experience everything. And I spent 4 months of my residency at Cedars at LA County USC Medical Center, which, in the early eighties, was the busiest hospital in the country doing about 22,000 births a year.

MARYN: Wow.

DR. STU: Which if you do the math comes out to be about 65 births a day.

MARYN: Oh my gosh.

DR. STU: It was entirely resident run. And the residents ran the floors on the fourth floor and the fifth floor. And on the eighth floor was the low risk midwifery floor, and, occasionally as a resident, we would go up to the eight floor to check on a heart rate tracing or to start an IV. That sort of thing. And I got to sort of—just at that point was my first exposure to midwifery care at all because we got none of it in residency program. I had none of it in medical school.

MARYN: Mm-hmm.

DR. STU: But I was exposed to sort of a different way of doing things and opening the doors onto the eighth floor you would find that there's a different—it was a different feeling than being on the chaos of the fourth and fifth floor. So—but that didn't really affect me that much. I came out of residency feeling like I was the smartest bulb in the—or the brightest bulb in the lamp and thinking that I knew everything about that—that there was to know about obstetrics. And boy, was I wrong. I knew everything there was to know about high risk obstetrics, but I knew almost nothing about low risk obstetrics or normal birth, which, of course as we all know, is about 85% of births are

normal. And yet, most residents and certainly medical students have no training in the normalcy of birth. We look at every birth as a potential disaster. And we're there to manage them not to observe them or not to support them or not to take our hands and sit on them.

MARYN: Mm-hmm.

DR. STU: And so I—in the early eighties, it was different than it is now. Doctors coming out of residency now generally apply for a job some place. And they get paid a salary, and they work a shift. And they don't carry a beeper, and it's sort of a nicer lifestyle. But it's not the same as it was in the early eighties where I was just hustling to build a practice. And I was approached by a couple of midwives, at that time, who had a birth center in Culver City here in part of Los Angeles. And they asked me if I would be their backup physician. In those days, back up physician had a different terminology than sort of what it has now. It's basically there wasn't the scrutiny that there was before. And I said, "Absolutely. Sure." I was happy to do it. I just was looking for the business.

And that was in about 1986. And I began to do back up for midwives for about 10 years. And I began to see a whole other way of looking at birth. I would just go to meetings with midwives sometimes. I would be able to sit and chat with them when they brought in a transport. And we'd sit in the doctor's lounge, and we would sit and talk. And I'd see sort of a different way of approaching these patients. The clients themselves. Even the word patient and client, I'd just mix them up because to me patients is what they are. To midwives, clients is what they are. And nowadays, I call my patients clients. I cannot get too confused with that. And I began to see another way of doing things. And I sort of started to unlearn everything that I thought I knew about normal birth. And in 1996, about 10 years after I finished my residency, a couple of midwives and I began to—they were certified nurse midwives, at the time, because they were the only ones that could have privileges at a hospital.

We opened up a collaborative practice between obstetrician and midwife. And for 15 years in Ventura County, which is just north of Los Angeles—actually, west of Los Angeles—we just—we practice in a style where the midwives took care of the normal stuff and dud the prenatal visits. And I did what I thought was the fun stuff. Interesting stuff. I would do the ultrasounds and the amniocentesis and the take care of the patients who developed high risk problems. And I would do the abnormal pap smears and the colposcopys and the surgeries, if we needed surgeries. And the midwives would do the well women exams. And it was sort of a really nice collaborative practice. The problem, of course, was that although our outcomes were really good and we had great patient satisfaction is that we were never accepted into the community that we were working in Ventura County.

And from the first day we were there, there was hostility towards us, specifically towards midwives, in general, and also toward the fact that I had the audacity to come in with midwives and start my own practice and not get permission from anybody or not follow the path that they like where it was sort of a good old boy network of doctors who did things one ways. And suddenly, there's this guy, and these midwives doing things a different way. And we're doing things that they don't do. And we're getting results that they don't get. And I don't—I can't read into their hearts and minds of what they were thinking. I can only tell you that they made it more and more uncomfortable. And over a period of time—while I'm still backing up other midwives that were doing home birthing, this practice taught me to look at birth a completely different way.

And after 15 years, it came to a point where the powers that be at the hospitals that I would working—that I was working at were—decided that they didn't really want midwives there anymore. And they banned them. And then, of course, prior to that they had banned vaginal birth after cesarean despite evidence to the contrary. Then they banned breech delivery, which, of course, I was—I had been doing and been well trained to do and had been credentialed to do. And it looked like we were headed for, "Hey,"—what's called an administration hearing or administrative fight over what we could possibly doing. And I was advised by people that, "You know what? You're going to go through this process. You're probably going to lose. And even if you win, all you're going to win is the right to stay at a hospital that isn't going to let you do what you want to do anyway."

MARYN: Right.

DR. STU: So some home birth midwives, who I had been backing for years, just said to me when we were just sitting around talking one time, "Why don't you come to a home birth?" And I thought about it. Like might as well—just asked me to do something like do gymnastics or go do pole dancing or something. It was completely foreign to me to actually think about going to someone's house and doing it. But I did. And that kid just turned 5 years old. I just got a nice note from the women, who I delivered. Was my first home birth.

MARYN: Oh sweet.

DR. STU: And I gave up my hospital birthing because you can't really do both. The system is such that malpractice and things would not work that way. And so I just began to do home birthing. And it's sort of taken off from there. And I just—I do breeches at home. I do twins at home. I do VBACs at home. I'm pretty much the only person doing most of those things. I'm the only home birth physician that I know of down here in the So Cal. Maybe some doctors might do one periodically under the radar. But I'm the only one that's openly doing it. And I recently am very happy to—that

I published a paper in a peer review journal on my first 135 home births, which is not—that took my 4 ½ years to get that many.

MARYN: Yeah. That's super exciting. Tell us about that.

DR. STU: Well, first of all, if people want to read it, they—at the top of my website at birthinginstincts.com is a banner. And they can click on that, and it'll take them right to the paper. But I had 135 home deliveries of which the C-section rate was 5.9%. And of those 135, there were 89% delivered successfully at home, and the transport was 11%. And those are pretty normal numbers except when you consider the fact that I did 32 vaginal birth after cesareans at home of which 30 were successful. And that's 93.8% success rate. And then I did 27 singleton breeches at home of which 22 were successful. And that's 82%. And the 5 that were not successful were all transported somewhere between 7 and 10 centimeters before arrested of dilation or for maternal exhaustion. And they had the option of a head—like a head first baby does of having an epidural and Pitocin.

MARYN: Sure.

DR. STU: I'm pretty sure that most of those women probably delivered vaginally too. But unfortunately, the breech transports pretty much understand they're going in for a cesarean section. And I did 12 sets of twins of which 11 were successful including one set of breech breech twins and 3 sets of vertex breech twins. All at home. All of these women that—that was, I think, 71 of my 135 clients were either breech, VBAC, or twins. And ultimately, some practices here in Ventura County or even in LA—all 71 of those women would have had a cesarean section, and we had 8.

MARYN: Yeah. That's amazing. I mean that's just such a great contribution to society to be able to prevent surgery unnecessarily when women don't want that option.

DR. STU: Yeah. Well, it just goes to show that if you train—if you have skilled practitioners following evidence-based guidelines with a midwifery model of care where you spend a lot of time with them and their prenatal visits are 30 to 60 minutes long—I know that most midwives their visits are at least 60 minutes long. It's pretty funny. When I was working—when working with a group of midwives at the sanctuary here in Los Angeles, we used to schedule my prenatal visits for an hour. And after a half an hour, I just didn't even know what to talk about anymore because I was so used to having a 6 or 7-minute prenatal visit.

MARYN: Yeah. That's a huge change.

DR. STU: Not even a half an hour. But—so my visits are usually 30-45 minutes long nowadays. And we end up talking about all kinds of things including the important

things like nutrition and stress reduction and rest and exercises. Those sorts of things that sort of get neglected in the medicalized model, which is designed to really treat women if they get sick. But otherwise, they leave them alone. Where the midwifery model is designed to keep people—keep women well.

MARYN: Mm-hmm.

DR. STU: And that's why you have better outcomes in the—when it comes to normal birthing.

MARYN: Sure. Sure. So what other principles of the midwifery model do you really feel like you've adopted and maybe changed or learned over the years? Because it's just so fascinating, I think, to have jumped—have made such a leap from hospital birth. I don't know. Even just in your head. Us midwives—we don't do that. So I think just to go from doing hospital birth and having all of that stuff at your disposal it might feel really, really different and kind of scary to be in such a different setting. So it's kind of two different questions there.

DR. STU: I was always very comfortable with birthing. But you're right. The word scary is important because the medical model is laced with fear.

MARYN: Mm-hmm.

DR. STU: And when you have fear, you end up with a lot of skewed informed consent. And one of the things I found about the midwifery model, to answer your question, was that if you don't have fear in pregnancy you can honor informed consent. You can actually do true informed consent. You can give women choices. And if they pick something that may have not been the choice that you would have picked, you can go with that. And you can honor that. And so that's one of the biggest things is the fact that I can, essentially, talk about, say, group B strep.

MARYN: Mm-hmm.

DR. STU: And somebody is positive for group B strep. In the hospital model, a women really has no choice.

MARYN: Right.

DR. STU: They're going to be told, "You need antibiotics, or your baby will get septic and be brain damaged."

MARYN: Exactly.

DR. STU: Same deal with breech. If they're breech, you—you need a cesarean section, or your baby will get its head stuck and get asphyxiated. And this is what they

tell people. And it's sort of what they know. And part of it is, I think, really—I'll just say it's really seen—it's really bad.

MARYN: Well, and it's part liability too, don't you think? I mean it's not just the lack of kind of new knowledge and experience.

DR. STU: Well, it's a misguided sense of liability.

MARYN: Right.

DR. STU: Because I don't believe that you get sued for things when you have good relationships and good communication with your patient. And you allow them to be very involved in the decision making process. I really—I don't see that as a big issue. And I think—I guess I've also felt that that is something I've inherited from the midwifery model. It's certainly not something in the medical model. And you give people the choices, and you can allow them to go this way or that way. We don't have—in my paper, one of the sentences I have is, "I allowed women who went beyond 42 weeks or had breech delivery or were over 35 to do whatever they wanted to do," because we didn't call them—we didn't label them high risk just because those terms existed. They're high risk when you are high risk.

MARYN: Right.

DR. STU: They call somebody high risk because she's 36 years old or because she's 42 weeks, and her baby—or even nowadays seen 40 weeks and 2 days is, "You're overdue. Oh my god. We've got to test your baby. We've got to induce your baby because your fluid is on the lowish side." No. You need to leave these people alone. You need to do the testing. You need to—you do—you mix the science with the nurturing. You come up with a better model, and you can get better results. And sort of that's what midwives do. And unfortunately, most of my obstetrical colleagues do not understand midwifery. They believe midwifery is a lesser subset of obstetrics rather than a separate profession. And really once—what we need to do is we need to sort of reeducate the world actually. Reeducate the pregnant women but also the medical world that obstetrics is—these people are professionals—midwives—who deal with low risk obstetrics. And that is their profession, which makes them experts at normal birthing and, therefore, they readily recognize abnormal.

MARYN: Right.

DR. STU: And so when something isn't normal, then they will refer. If and when they have smooth transition, the problem is the barriers to transition, the barriers to collaboration that are put up by some of the misinformation, some of the fears, some of the liability issues that you spoke of.

MARYN: Mm-hmm. Yeah. Yeah. It's a very complex issue, but I agree. I think, on the most positive note, all we can do is continue to offer women choices. And, again, I just really honor you for being one of those people because stereotypically, of course, it's just more of a control issue. And that goes for a lot of midwives too. But, again, true informed choice or informed consent or whatever you want to call it is really rare. But I totally agree. That's where people fine their power. That's where they find their responsibility. And just being there to support that choice as best you can is really what we've got to do.

DR. STU: Yeah. I mean just today I saw two clients that had—first time interviews. One is almost 42 weeks. And here in California, we have a law that a midwife can't attend a birth after 42 weeks. So sometimes they'll ask me to come on board and take over sort of on paper and in presence the care although the midwife is still the one that actually will be caring for her and delivering in labor. I will be at the birth.

MARYN: Sure.

DR. STU: And then I had somebody who came in for what's called a VBAC consultation, which is because even though pretty much it's agreed that VBAC is something that midwives are going to get to do in California the regulations have not been written clearly. And so most midwives are still sending people in for a medical clearance for VBAC, which, of course, is ridiculous because VBAC is rare. And VBAC is unpredictable. And so how does seeing someone at 18 weeks and getting medical clearance for it make any—make it any less rare or less predictable—I mean more predictable? It doesn't.

MARYN: Right.

DR. STU: I mean it's not like hyperthyroidism. It's not like hypertension where medical consultation makes some sense.

MARYN: Mm-hmm.

DR. STU: And they both were telling me stories of their prenatal care or their first birth in the case of the VBAC. And it's like I want to sit there, and I want to pull my hair out because—

MARYN: Oh gosh. Yeah.

DR. STU: - the story of the things that the doctors had said to them and the insanity of—and the tragedy sort of even in their voices and the tears that come to their eyes when they talk about, for instance, the VBAC talking about her first birth. And the things that she was put through, and it was every possible intervention that you could think of for absolutely no reason.

MARYN: Yeah. Yeah.

DR. STU: I'm sure her doctor thought that she was doing the right thing. So the question is how do we break through that paradigm. How do we reach the next generation of OB/GYNs and let them know? And the projects that some of us are working on like your project and some of the documentaries that we've been involved with and hoping to get some lectures going with residents. Because people that have been out practicing for 20 years, they're not going to really change their [cross talk] very much.

MARYN: Right.

DR. STU: But if you can get to the younger people and they can realize that a collaboration can do better and can have a system—a lot of the criticisms of the home birth world here is that we don't have good collaboration like they do in England. Because in England, they're promoting home birth for the low risk women. And they argue that the people here that hate home birth in America will say, "Well, England has a good collaborative system."

MARYN: Right.

DR. STU: Well, my answer to that would be not, "We should get rid of home birth," but how about let's develop a collaborative system. So—

MARYN: Right. Yeah. Yeah. It's definitely a multilayered issue. I mean I agree the upcoming doctors have no knowledge of any of this it seems. And then on the other hand, you're seeing these clients that midwives are having to transfer care for. And that's a whole other issue is that's the normal model, and many normal, healthy women are being forced out of that box too. So where you're at in California, it's awesome that women have that option. But you know, it's just not that—it's not that common. And women all over this country and the world are finding themselves in those situations where they're 42 weeks, and they suddenly have no one.

DR. STU: Yeah. Because no doctor is going to pick them up at 42 weeks. And the midwife is breaking the law in California if she takes care of them at 42 weeks. And so what happens is at 41 weeks and 4 days or something, they're starting to pour down the castor oil and put on the evening primrose oil, and they're having sex up the wazoo and doing—pumping their nipples and all these things when they should just be leaving their baby—letting their baby come when it wants to come. And surely doing—I think biophysical profile is a reasonable thing to do to make sure that it's okay to keep going. But if those things are normal, then there's no reason that you need to necessarily intervene. And these women are all scrambling because they know that in 2 more days

or 3 more days they're screwed. And even if they're not screwed, it's going to cost them more money even if they have me as an option.

MARYN: Yeah. Yeah. No, totally. I mean those are the situations we find ourselves in here. And it's not ideal because that's not the midwifery model. It's not the midwifery model to meet somebody as great as they may be and have them appear at your birth 24 hours later. It's just—it's not what it was based on. So things get a little skewed, I think, when those things happen.

DR. STU: Right. So that's why we need to keep speaking up, and we need to keep doing it in a rational manner. Not confrontational. And we need to—when we are belittled or when midwives are vilified or whatever else, we need to respond with kindness and education. Not necessarily with vitriol because that doesn't do anybody any good. And there are a couple—there are a couple of antagonists. Specifically, I'm thinking of two guys out of Cornell University who just seem to be coming up with stuff constantly that is anti home birthing. And their papers and their arguments are so easy to tear apart and break down, but they have credibility. And any article that's written in the *Wall Street Journal* or *TIME Magazine*, everything, they always go to these two guys for their quotes.

MARYN: Mm-hmm.

DR. STU: And it's like oh my god. Not these two guys again. But that's just the way it works because they have credentials behind their name. And that means when a reporter, who knows nothing, is writing an article. So what we need to do—that's why I want to get my paper published and stuff like that, so that we can start to add some legitimacy to the world literature. I mean if you look at the work of Sarah Buckley, if you look at—well, Sarah Buckley, in particular, but we just had the Better Birth World Summit 360. And there are a lot of luminaries there. I don't know how many people. I think Nicholas Olow had about 30 or 40 different—

MARYN: Yeah. He did a lot. Mm-hmm.

DR. STU: And there's some really good articles. But I would suggest anybody listen to Sarah Buckley's talk. Because she has a lot to say about the hormonal view and the—how interventions screw up the physiology—the hormonal physiology of birth. And what we are—not only what we are doing acutely but what we're doing long term to future generations may be significant. Because when you mess with Mother Nature, you—there are consequences. It's not always perfect. Even something as good as penicillin and all the good it has done in the world, well, if you use it too much, it would help select out super bacteria. It will help to change the flora of babies that are being born and cause—many problems we are finding out are causing problems within intestinal tract

and autoimmune disorders down the road, if we're giving—indiscriminately giving antibiotics to these women when they're pregnant.

MARYN: Sure. And what about even generations down the road? I can never help but try and see the bigger picture. That what we're screwing with isn't even our births now. It's just what's to come. We don't know.

DR. STU: Well, there is a lot to do with epigenetics and even oxytocin receptors on the uterus's of female fetuses whose mothers get synthetic oxytocin. There's a question of whether or not they'll develop enough receptors in the future to actually have a labor themselves.

MARYN: Yeah. That's fascinating.

DR. STU: These are great theories. And yeah. I mean they're all theoretical. But when I look at science, stuff like that, I sometimes say, "Do we really need to study to prove what common sense would tell us?"

MARYN: Mm-hmm.

DR. STU: And a good theory—one of my mentors here in Los Angeles has—I've heard him say it many times is studies either show what common sense would tell you, or the study is wrong. And that's pretty much the truth. To know, to understand that we need to study to prove that messing with birth and giving every woman an epidural and every woman induction and everyone 30% getting cesarean sections is not going to mess with something, that's foolish to think that way.

MARYN: Yeah. No. It totally is. I think people nowadays though, particularly with the Internet, women are searching for information. And that's what I love about Sarah Buckley's research and all of her books and all of her available resources it that it's pure science. It appeals to most people. It appeals to the partners. And they can really get behind why normal physiological birth makes the most sense. It's not some hocus pocus theory or hippy midwife sitting in a corner knitting. It's actual science. So I think—

DR. STU: Yeah. Wouldn't it be great if that—wouldn't it be great to have a nationalized—national televised debate with Sarah Buckley at one point on the stage and somebody like—and then some of these Cornell guys like [inaudible] or [inaudible] on the other stage. And actually how the dialogue between the two as opposed to—what I—you can't have science by press release. And unfortunately, that's what we've come to now is somebody will put out a press release regarding their paper that's going to come out next month. And even when the paper comes out or it doesn't say what the press release said, the damage is already done. And then if you write a letter to the

editor arguing about that, you only get 350 words. And then the author gets 600 words to rebut your 350 word argument, but you never get to actually have a dialogue.

MARYN: Yeah. Yeah.

DR. STU: And it's just not a good way to—for teaching. It's not a good way for learning. And it's certainly not a good way for collaboration.

MARYN: Well, and it's not a good representation, I think, of where I would love to see women really feeling and thinking about birth because all of that mental mumbo jumbo is only good for so much. And it takes the place of the connection that women have and the intuition. But that's sort of the tactic, I think, is to focus on this mental part and just have her neglect what she knows. And that kind of goes along with the hormones and stuff too really.

DR. STU: Yeah. I mean what really would be great—and maybe you can put this out there for your—for the attendees of your conference is to ask all of them to ask their obstetricians to come to your conference.

MARYN: Yeah. Wouldn't that be something? Especially here. I mean I would probably fall over if—yeah. I mean they may come to heckle us.

DR. STU: Offer them free massages. Or offer them free tuition.

MARYN: Oh my gosh.

DR. STU: Or offer them free something so—a free spa day for the doctor who comes to listen to some of these lectures.

MARYN: Yeah. It's really not a bad idea. That's actually an awesome idea. So I am going to write that one down.

DR. STU: Because it would turns out—it happens all the time at conferences like this is that we end up preaching to the choir.

MARYN: Exactly.

DR. STU: And we're surrounded by lovely fellow travelers, but we rarely get in somebody else who can present their side of the argument and ask questions that would be sort of delicious to hear. We could discuss in front of—to hear somebody else's position. People don't like to be immersed into things that make them uncomfortable. It makes—it'll be uncomfortable to talk about a lot of the things that you and I have just talked about over the last half hour.

MARYN: Yeah. Yeah. No. For sure. And yeah. I agree. And I struggle as well with the preaching to the choir, but I think bringing you to this conference is going to be really eye opening even for midwives that are on the same page. And so I'm bringing us to our next topic, which is I want you to talk about breech. I want you to talk about how passionate you are to keep this art alive because preaching to the choir or not midwives are not learning this skill. You know that. So even if that's why they're there and all we kind of get accomplished, I will feel really good about it, if they come away feeling more encouraged and they feel like they've learned something.

DR. STU: Yeah. I think—to learn breech delivery, ideally, you need to actually do them.

MARYN: Exactly.

DR. STU: The problem, of course, is that there's probably no place left in the United States, at least right now with enough volume for people to actually learn to do them comfortably outside of the—of that sort of setting where they might get to do a couple of them. So I've thought about this a lot. And ultimately, what we'd like to do eventually is set up a center somewhere whether it's in California or whether it's in Oregon or whether it's in Arizona or some place that—but it needs to be near a fairly large population center where we get—a breech center where we can actually have enough volume where we can approach residents and midwives in training or even ones who are out who want to get the training to come and spend a month or two months and get enough breech deliveries. But they're doing that in Frankfurt, Germany and a few other places. But it's not the same idea of what—I mean they're academic institutions doing research. I don't really want to be doing research. I want to be teaching clinical skills.

What I'd like to do at the conference is since obviously we're not going to have a breech delivery on stage is I'm going to talk about my criteria for breech delivery. I'm going to show some videos of breech delivery. Some are amateurs. Some are professional. Some of the breech deliveries I've attended on all fours or on their back in the standard, sort of—modified lithotomy position. And go through the maneuvers and tell you what you should do in this situation, what you should do if it's frank or complete. What do you do if a foot pops down? What do you do if you can't get an arm out? What do you do if the arm is stuck up over the head? What do you do if—how do you get the head out if the head is not coming easily and these sorts of things? We'll go through all those things. But clearly whether you see it on film or you work on a simulator, it's not the same thing as dealing with a living, breathing, panicking human being when your pulse is 140 and your blood pressure is 180 over 110 because—

MARYN: Yeah. No one's promising calm here. At least internally.

DR. STU: Yeah. The beauty of doing these things at home ever is that—for me, among other things about home birthing is that we don't—I don't have a bunch of panicking anesthesiologists and nurses and other people standing around—

MARYN: Oh, I can't imagine.

DR. STU: - looking nervous. It's just me and the midwife or me and the midwife and our student. And the father in the room or the doula. But it's people who are all quietly supporting the situation, and there's not this having a NICU team standing by because the baby comes out and it's not screaming right away. It's a whole different philosophy. If the baby is good going into the second stage, babies generally usually come out fine in the second stage. So there's a lot to breech skills. I hope we will talk—at least one of the lectures or part of my lecture will be on that topic because all of us are going to be in a situation sometime where it's oops. I thought the baby was head down, and now there's a foot sticking out. And we're 45 minutes or an hour from any major help. What are we going to do? We need to know what to do.

MARYN: Yeah. Yeah. That's why I don't quite understand why everybody isn't super excited about learning about breech. I mean that's what I figure. It's going to happen to someone and everyone sooner or later. So if nothing else just not being fearful and—

DR. STU: Well, it is a big—it is a big, big thing with me and my complaint against current residency training programs because obstetrical training programs are supposed to teach future obstetricians the skills that make obstetricians unique. And that isn't a cesarean section and a pap smear. That is doing colposcopy and doing breech delivery and reaching up and extracting a second breech or putting on forceps or doing external version or using your hands and stuff. They're not teaching that anymore. And so there's—the video they—the documentary we just came out with is [inaudible], who I just met for the first time at the screening which was 4 years after the birth of her baby that's on the film. And she's still traumatized by it because she came in basically completely dilated with the butt protruding. And they pushed the baby back up and did a C-section.

MARYN: Oh my gosh.

DR. STU: Because no one knew what to do. Which is still kind of odd because you have to know how to do—even if you do a cesarean section, you have to know how to do a breech delivery because it's still a breech delivery.

MARYN: Yeah. That sounds like pure panic to me.

DR. STU: Yeah. And she says that. She says they were panicked. And that's a shame because this is a thing that happens 3 to 4% of babies are breech. Obviously, they're

not all surprise breeches or planned breeches. But even so, it's kind of—it happens far more often than a seizure, an eclamptic seizure, and everybody knows how to deal with that.

MARYN: Yeah. Yeah.

DR. STU: I hope everybody knows how to deal with that.

MARYN: And that's another topic. Yeah. Yeah. Obviously, I agree. And I'm concerned that midwives also don't have the skill. The older midwives that I know that have attended breeches—well, those are the only midwives I know with the skill. I don't really know any newer midwives. I know that if it's a known breech for any midwife here, at least, it's obviously an automatic transfer of care and then a C-section. There's not a whole lot of impetus to really learn or to really provide any choice. And, of course, a lot of that is political. But, again, it's just looking at the big picture. Doctors don't have the skill, and that's a whole thing. But yeah. Midwives don't either. And that's just a really big issue.

DR. STU: Yeah. I mean you can't be pointing fingers at physicians who don't know how to do because they're weren't trained.

MARYN: Right. Right.

DR. STU: But I can point fingers at training programs. And I can point fingers at state governments who take away the right of people who know how to do breech deliveries from doing breech deliveries.

MARYN: Right.

DR. STU: It's bad enough that doctors don't know how to do breech deliveries here. But midwives who know how to do breech deliveries are now banned in California from doing them. It's just sort of—it's really stupid. It's all done in the name of safety, which, of course, we all know is a canard because safety is not the motivating factor. But it is a good hammer on which to get people to do what you want them to do.

MARYN: Right. Right. And I always say too the definition of safety really means infallible. There is no such thing as that in birth. There's no such thing as 100% safe or perfect. So when people get on that bandwagon, I just don't know what to say.

DR. STU: Well, and they train—they trade one risk for another risk or one safe boat for a different safe boat. I mean the problem—another thing too that doctors either don't understand or purposely don't understand, which is worse, is they don't understand—or they don't explain well the difference between relative risk and actual risk. And some thing is safe for a VBAC may have a relative risk of rupturing the uterus that's greater

than somebody who doesn't have a VBAC, but—or doesn't have a previous cesarean section. So you can scare somebody into saying it's risky. On the other hand, the absolute risk is actually quite small.

MARYN: Sure.

DR. STU: But that's not what's said. They skew their counsel to get people to do what they want them to do. And that violates every tenet of the American Medical Association's Code of Ethics. And we'll talk a little bit about that at the conference as well.

MARYN: Yeah. Yeah. I don't think I told you, actually, but we want to do a panel on risk. So you and the other midwives that are there. So we'll get a lot of chance to talk about risk.

DR. STU: Well, I'm not going to say any more about that because [cross talk] to say.

MARYN: Yeah. So don't say anymore. Yeah. No. Don't say it all now.

DR. STU: You might uninvited me now that I've done this talk. You say we don't need him to come anymore.

MARYN: No. No. No. No. In fact, I have a million more questions but no. I'm not going to ask them. I want to keep everybody intrigued to meet you and hear you speak. So we're just so excited to see you, to have you here in Sedona, to spend time with you, to just hear you, and just kind of be together in this even if we are preaching to the choir. Maybe we'll get the word out. Who knows?

DR. STU: Yep. And ultimately, if anybody in the—listening audience knows a physician who has some skills, who is disgruntled with hospital based practice, I am desperately looking for a protégé who wants to come into the home birthing world with me because, ultimately, it's really hard at this point in my career because I—if I have a breech or twins, something that I'm only allowed to do and midwives aren't, it's hard for me to go away. It's hard for me to go to conferences in Sedona, Arizona, and get away when I have people due. And it's always very stressful, and I don't really want any more stress in my life right now. I'd like to have a protégé who really wants to honor the profession and honor the women that he's taking care of by giving them really informed choices.

MARYN: Yeah. That is quite an opportunity. I don't know that any doctors will be listening to this. But hey, we can forward it on out there and hope because that would be an amazing opportunity. I know I'd—

DR. STU: Yep. I know I've heard from my ethereal friends that if you just put it out there in the ether that if you really want it bad enough it'll come. So I'm throwing it out there

and, hopefully, one of my wishes will come true if somebody will hear it. And it will be answered.

MARYN: Yeah. Sounds good. It's all about the intention. So well, thank you so much for sharing with us.

DR. STU: I was just going to say I was at services this weekend for the Jewish holiday. And one of the guy who gave the sermon—he wasn't a Rabbi. He's a lecturer. He gave the sermon. And one of the things he said which was very good about—he talked about God and prayers and life. That 6 million Jews were killed. And why should we believe in God? And that sort of thing. And he said—he says, "People—or God hears all prayers. It just doesn't mean He has to answer them all." But He hears them all. He just can't answer them all.

MARYN: Well, and who knows when, right? It may happen when you least expect it. Or—

DR. STU: Well, I have no expectations, so it actually—anything would be good—anything would be better than that.

MARYN: Yeah. Well, that would be awesome just, obviously, in the bigger picture too. It's more people, more people, more people that care and want to continue this work because none of us are going to be around forever. So do the best we can and hope that more people follow suit.

DR. STU: That's right.

MARYN: Yeah. All right. Well, thanks again. Thanks for listening everybody. Remember to check out Dr. Stu's website, birthinginstincts.com, to learn more about him before the conference. And, of course, indiebirth.com/conference has all the conference information there. Thanks so much and have a great day.

(closing music)