Forum

Natural birth: improved outcomes for both mother and child

Lisa Muscarella, Kathy Blanco, and Donna Young

Abstract

This forum consists of three mothers who each candidly share their birthing experience and knowledge in the hopes of educating pregnant mothers and effecting sorely needed medical reforms. Lisa Muscarella discuses how proper birthing position can achieve as much as 30% greater opening of the birth canal, thus reducing the risk of shoulder dystocia, brachial plexus injuries, and other injuries to both mother and child. Kathy Blanco's personal experience and narrative demonstrates the positive birthing outcomes associated with natural birthing methods and contrasts these with a pregnancy where labor was induced using drugs, a pain killer was administered, and the umbilical cord was instantly clamped. Since 1998, Donna Young has been engaged in extensive research, and is most qualified to discuss fraudulent policies, procedures, and protocols that have become established for the benefit and convenience of the healthcare profession, rather than serve the interests of the mother and well-being of the baby.

Keywords: natural birth, birthing position, immediate cord clamping, labor inducing drugs

Introduction

Childbirth experiences are not only individual, but can vary immensely from one pregnancy to the next. These birthing experiences are instructive and provide insight as to the standard of care that should be exercised by healthcare professionals and expected from birthing facilities. Truly informed consent is lacking when it comes to birthing procedures. Prenatal classes do not share the harm caused by birthing semi-sitting or flat on the back, the risk of drugs crossing the placenta, or informed choice of no umbilical cord clamping. Occasionally, one or more complications can arise during childbirth, for example placenta previa, necessitating medical interventions that may include a C-section to prevent the mother from bleeding to death or the child from being stillborn. All three mothers indicated that they would have certainly done things differently or chosen different options had they been truly informed. They have all learned from their past experiences which are not unlike many other mothers who were neither fully informed nor prepared for delivery. We hope this introductory Forum will encourage readers, both husbands and wives, to continue to do further research so as to have a positive birthing experience.

Current birthing position is challenged

Unfortunately, many physicians (especially in the U.S.) are incorrectly instructed that the "on-the-back or semi-sitting routine positions, including knees retracted," duplicate the natural squatting position of delivery. Only the natural squatting position takes full advantage of gravity and allows full opening of the birth canal.

Use of episiotomy procedure is challenged

There is no scientific evidence supporting the use of episiotomy as a beneficial surgical procedure in the majority of instances that physicians opt to perform it. It does not decrease the risks of severe perineal lacerations; it inhibits development of pelvic relaxation, and it has not impacted newborn mortality or morbidity. Improving the birthing position likely can help maintain the integrity of the perineum and avoid surgical procedures that should only be employed on a selective case-by-case basis [1].

Use of immediate cord clamping (ICC) is challenged

Another widely used routine procedure involves immediate or early cord clamping (ICC/ECC). A nine-pound [4.1 kg] newborn has approximately 10 ounces (300 ml) of blood. Immediate clamping of the umbilical cord can reduce the red blood cells an infant receives at birth by more than 50%, resulting in anemia and other potential short- and long-term problems [2. Delayed clamping has been shown to have many benefits, including higher hematocrit and hemoglobin levels, improved blood pressure and volume with better cardiopulmonary adaptation [3], less infant respiratory distress syndrome (IRDS) [4], and reduction of Hyaline Membrane Disease (HMD).

ICC interrupts the infusion of blood into the expanding lungs, damaging the lung sacs [5]. A recent study concludes that delayed cord-clamping in preterm infants is associated with reduced need for transfusion and less intraventricular hemorrhage [6]. ICC/ECC may be responsible for increases in brain damage and autism and such infants where these procedures are used may be more susceptible to adverse vaccine reactions [7].

Babies that have been quickly cord clamped are weaker than those where clamping has been delayed. If the newborn baby is not kept warmed and wrapped, hypothermia can occur, causing pulsation of the cord to cease unnaturally early. While scientific studies have shown that delaying cord clamping by only 30 seconds yields health benefits compared to ICC, all early clamping of the cord deprives the infant from the full health benefits that derive from letting all blood infuse.

Medical persons have long known the facts concerning improper handling of the umbilical cord and the injurious affects [8]. In 1801 Erasmus Darwin in *Zoonomia* (volume 3, page 302) writes, "Another thing very injurious to the child, is the tying and cutting of the navel string too soon; which should always be left till the child has not only repeatedly breathed but till all pulsation in the cord ceases. As otherwise the child is

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much weaker than it ought to be, a portion of the blood being left in the placenta, which ought to have been in the child."

Interestingly, ICC became more widely used as medical institutions began harvesting placenta blood, including the cord, membrane, stem cells, and associated enzymes and hormones [9]. Contracts used by medical institutions that are signed by the mother (as patient) often indicate that the placenta will be "properly disposed." This language has allowed for research use and third-party sales of the cord and placenta. The mother should designate that both cord and placenta are not to be used further by the medical institution or other third-parties.

Use of labor inducing drugs is challenged

Finally, labor inducing drugs such as Oxytocin, Toesen, Syntocinon, Pitocin have been shown to have a negative effect on the child's developing brain. When these drugs are administered to the mother, since they can travel to the baby through the placenta, immediate cord clamping is necessary to prevent the baby from suffering brain damage; however, the clamping can cause the infant to experience anemia. Recent studies have called for a re-evaluation of routine use of these drugs due to their adverse effects on the newborn. Another drug, Demerol® (or Pethidine) has been found to have long-acting behavioral and neurological effects in newborns due to slow elimination. As a result, breastfeeding is delayed and the mother-infant interaction is disturbed [10].

Conclusion

In conclusion, it is imperative that doctors practicing obstetrics remember their number one ethical duty to "Do no harm." Until such time as doctors adopt routine and standard protocols that keep the mother's safety and the well-being of both mother and child as the top priority, it is recommended that the mother devise a Birth Contract/Waiver and have it witnessed. Signed by the doctor, it becomes a guiding medical directive superseding any policies that may have been adopted by the healthcare establishment to promote time efficiency or convenience of the doctor or medical staff.

Pregnant mothers must question the fraudulent policies, procedures and protocols that have often come to define current standards of practice and which have contributed to the U.S. ranking 28th below other nations in infant mortality rates. Healthier outcomes for both mother and child can and are being achieved when mothers are truly informed and discuss with their physician topics that include (1) birthing positions, (2) under what specific circumstances procedures such as episiotomy and C-section might be performed, (3) use of long-delayed or no cord clamping, (4) no use of oxytocic drugs to induce labor or other interventions without informed consent.

A hospital's or doctor's acceptance of the current standard policies, procedures and protocols, is not a guarantee that such interventions are scientifically or medically effective or safe. Physician's training is often compromised by conflicts of interest with the pharmaceutical industry, hospital incentives for enrichment through sales of biological products (including placenta blood and other cord products), and other biases.

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Proper birthing position: reduces risk of shoulder dystocia and injury to the baby

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Abstract

Thousands and thousands of newborns are injured each year at birth, as was my son. When a baby's shoulder gets impacted in the birth canal, a medical provider can overreact and apply excessive traction to the baby's head and neck in an effort to dislodge the shoulder. This may cause severe nerve damage to the brachial plexus, resulting in paralysis of one or both arms and/or hands. After my son's injury, I was told that my pelvis was too small for my baby, which resulted in him getting stuck. I felt so very guilty and anatomically inept, since I believed that my pelvis was too small to safely birth my baby. Since my baby's injury, I have come to learn that it is not so much my anatomy that is in question, as it is the standard and routine practice of having women deliver on their backs. Women were not designed to give birth on their backs or semi-sitting. Such positions do not allow full sacro-iliac joint motion to occur and instead place most of the woman's body weight squarely on her tailbone, forcing it upward and restricting it from freely moving backwards. Scientific research supports the notion that such positions may actually close the mother's birthing canal by up to 30%, thus not allowing sufficient opening for the baby to safely pass through. If birthing mothers were not on their backs in the first place, there would be significantly less complications, less trauma and less injury to babies and mothers as well.

Keywords: brachial plexus injury, shoulder dystocia, birth positioning, birth trauma, birth injury prevention, birthing safety

Four years ago, my son sustained an injury at birth, known as a brachial plexus injury (BPI). He was a big baby, and during the time of delivery, after his head came out, his shoulder became stuck, a phenomenon known as shoulder dystocia. Shoulder dystocia can result in clavicle fractures, fracture of humerus, brachial plexus injuries, fetal hypoxia, with or without permanent neurological damage, or even death. Although shoulder dystocia is fairly common and something that all obstetrical health care professionals find worrisome, some physicians and medical staff are not adequately prepared or trained to handle it properly. Instead, some panic or overreact, applying unnecessary and excessive traction to the baby's head and neck in an effort to dislodge the baby. This is tragic because applying excessive traction to the baby's head is not one of the maneuvers designed to release the baby, actually it is clearly contraindicated, since pulling or turning the head can tear the nerves coming from the baby's spinal cord.

Immediately after my son's birth, his arm was completely limp, lifeless and paralyzed due to the severe damage of the nerves (the brachial plexus network of nerves) that come from the neck and down into the shoulder, arm, elbow, wrist and hand. Through endless hours of daily therapy over the years, and surgery, he has regained much function, but has many limitations, weakness, deformity of the shoulder joint, deformity of the elbow joint, along with many other lifelong issues. Any individual or family that has lived with this injury knows just how difficult and painful this journey is.

We were fortunate enough to have captured our son's birth on video, by our then 13-year-old daughter. Sadly though, the hospital banned video taping births shortly thereafter. To my dismay, I have learned that such banning has occurred at many hospitals across the U.S., despite possible censorship violations. I suspect our hospital banned video taping shortly after my son's birth because nothing has the potential to more clearly depict improper handling of a birth and provide documentation of what truly occurred during a delivery, than live video footage which could potentially be used as evidence in a malpractice suit.

Without a video of the birth, it can be next to impossible to confirm what really transpired behind closed doors. I have been dumbfounded by the stories of families that were well aware that a shoulder dystocia and excessive traction occurred during the birth of their baby, yet upon receipt of their medical records, the occurrence of shoulder dystocia was not even noted. Concern of possible legal repercussions, causing a doctor to leave the incident undocumented, surely does not imply that shoulder dystocia did not occur.

Unfortunately, clear risk factors for shoulder dystocia are not always apparent and cannot be consistently used as a means of determining when a shoulder dystocia will occur, thus reminding us of the importance of taking a preventative stance and not using birthing positions that close the birth canal. Large infants are at higher risk for shoulder dystocia, but average weight infants may also suffer this complication. Additional possible risk factors may or may not include the following: prior birth with shoulder dystocia, prior macrosomia (large baby), pre-existing diabetes or gestational diabetes, obesity, advanced maternal age, excessive maternal weight gain during pregnancy, postdatism, prolonged second stage, protracted descent, abnormal first stage, and the need for mid-pelvic or assisted delivery.

Although extremely rare, this birth injury can occur with a cesarean section. Those of us in the brachial plexus injury community are well aware of, or personally know, mothers who were given cesarean sections with very small incisions. This can unfortunately result in doctors tugging too hard and in an inappropriate manner on babies, while attempting to pull them out through the tight incision, thus potentially resulting in a BPI. Some scientific literature states that these injuries can be caused by strong contraction in utero; however, in general, there appears to be more reliable evidence that contradicts such reports than supports them.

Recoveries from this birth injury vary from child to child. Some children have complete recovery in time, some have partial recovery, and some have limited, if any, recovery. Brachial plexus injuries are known to be one of the most complex injuries that exist

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(next to spinal cord injuries) and they are often misunderstood, especially in terms of treatment and the long-term implications, which are numerous.

Brachial plexus injuries, also known as Erb's Palsy and Klumpke's, occur much more frequently than people realize. This injury affects approximately 10,000 to 12,000 babies each year in the United States, which translates into the statistic that more than 1 baby is being injured (usually needlessly) with every passing hour of every day. Brachial plexus injuries are one of the most litigated, if not *the* most litigated of all birth injuries. They occur in an estimated 2 to 4 per 1,000 births. More newborns suffer birth-related brachial plexus injuries than Down's syndrome, Muscular Dystrophy and Spina Bifida. This birth injury also occurs as frequently as Cerebral Palsy, yet it is often swept under the rug, and not even mentioned in many prenatal books. Why?

The answer to this question may include a variety of factors. Perhaps it is because the medical field continually minimizes the injury and does not acknowledge the possible lifelong implications. Sadly, many mothers are sent home from the hospital with their baby's paralyzed arm pinned to their shirt, with little or no information, and are told by the physician, "Your baby should be fine in a day or two." Perhaps this injury is swept under the rug because it is caused by the very hands of the doctors and midwives who have unnecessarily injured our babies. Perhaps it is because traditional hospital birthing positions often keep birthing mothers on their back or semi-reclined, needlessly closing birth canals by up to 30% when trying to push a baby out.

Through research, attending conferences, and by talking to as many people as possible, both mothers and professionals, I have come to learn that birth positioning can be of paramount importance when it comes to preventing various complications and injuries to both mother and baby. Birthing on one's back can lead to closing the birthing canal, compressing major blood vessels, interference with circulation and decreasing blood pressure, which in turn lowers the oxygen supply to the fetus. Humphrey et al. (1977) and Kurz et al. (1982) provide evidence that suggest if the mother lies on her back it can lead to reduced placental perfusion, diminished fetal oxygenation and reduced efficiency of uterine contractions. J. Roberts (1980) compared different studies on maternal positions and found infants birthed in the lithotomy position had higher acid levels. In addition she also noted, "fetal hypoxia and bradycardia have been associated with the supine position." Such positions can clearly put unnecessary stress on the baby.

Pushing in a supine position can be more difficult for mothers because they are now having to work and push against gravity as opposed to with it. This can directly increase the need for forceps or vacuum extraction, which in turn increases the risk of physical injury and damage to the mother and baby. Mothers report back pain is worse when birthing on their back and some even experience broken coccyx bones. There is also increased tension on the pelvic floor. In addition, such positioning can lead to less regular, and weaker contractions, which can result in a failure to progress, a cesarean section or an assumed need for pitocin, which may be the beginning of a potentially harmful cascade of interventions. On-the-back positions also increase the likelihood of having an episiotomy, and due to excessive stretching of the perineal tissue in such positions, mothers are much more likely to suffer from severe tearing of these tissues.

It is evident that women should not birth on their backs in commonly used positions such as dorsal lithotomy or semi-reclined, which force the sacrum upward and restrict it from freely moving backward as the baby passes through. Scientific research (Russell JGB 1969) supports the notion that such positions may actually close the mothers birthing canal by up to 30%, thus not allowing enough room for the baby to safely pass through. In 1911 Whitridge Williams, original author of *Williams Obstetrics*, clinically demonstrated 4 cm of sacroiliac motion.

Physicians and medical staff should always take a preventative stance by not having women birth on their backs in the first place. By accepting change in traditional positioning used in hospitals, and by accepting some minor inconveniences to themselves, medical providers can provide a safer delivery for the baby and mother, with less complications and less risk of injury. The priority should *always* be the safety and well-being of the mother and baby.

Many shoulder dystocias would be prevented by proper biomechanical positioning, which would allow the birth canal to fully open. If the baby's shoulder gets stuck, the mother should be repositioned immediately to get her off her sacrum, and practitioners should wait calmly for the assistance of the next contraction. Mothers should *not* birth on their backs, nor should medical professionals be allowed to promote birthing positions that can significantly close the birthing canal and potentially harm the mother and baby. If for some unfortunate reason a woman is on her back, she can easily be rolled off her sacrum onto her side. Supporting the woman onto hands and knees, upright or squatting position can help tremendously in preventing or alleviating shoulder dystocia by allowing the sacrum to freely move back as the baby is trying to pass through. Such positions also work with the benefits of gravity to assist in expelling the baby, and provide the baby with an easier and more effective position and angle for delivery.

Dr. William Sears states, "the best birthing position used by mothers the world over is squatting." He goes on to share that squatting speeds the progress of labor, widens pelvic openings, relaxes perineal muscles so there is less tearing, relieves back pain, improves oxygen supply to baby, and facilitates delivery of the placenta. Many women have been supported into hands and knees position, squatting, etc., even with epidurals, and side-lying can be accomplished with the greatest of ease for those who have anesthesia.

Physicians are often taught to apply "gentle" traction during a shoulder dystocia. This is truly a dangerous practice that needs to become obsolete. Medical providers would be wise to leave their hands off of babies' heads at the time of delivery, especially during a shoulder dystocia. Any recommendation of applying any amount of "gentle" traction during a shoulder dystocia appears to be a possible prescription for injury, and the only individual who can truly define what constitutes "gentle", is the baby—not a panicked or stressed doctor who can unintentionally apply too much of his or her adult strength, and end up trying to pull or twist a baby out of its mother. By getting mothers off their backs and avoiding the dangerous protocol of applying so-called "gentle" traction to the baby's head, brachial plexus injuries would immediately almost cease to exist.

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Additional documented interventions designed to resolve a shoulder dystocia include such maneuvers as the McRobert's, suprapubic pressure, deliberate fracture of the clavicle, delivery of posterior shoulder, Zavanelli, Woods' or Rubin's maneuver. However, the effectiveness of some of these maneuvers appear to remain somewhat questionable. And whether or not the McRoberts, depending on the how it is performed, actually opens or closes the pelvis, is yet to be adequately determined. Interestingly, the Merck Manual, 7th Edition states, "When shoulder dystocia occurs, all available personnel should be summoned to the room, then the mother's thighs are hyperflexed to increase the diameter of the pelvic outlet." One cannot help but question the logic of the McRoberts maneuver (sharply hyperflexing the mothers thighs upon her abdomen), as an attempt to provide more space for the baby that should have been provided initially. Intervening to get a baby unstuck makes little sense in comparison to allowing the birth canal to fully open, providing the optimal and maximum space, and preventing harm to a baby in the first place.

Another maneuver used to resolve shoulder dystocia is called the Gaskin maneuver and is named after renowned midwife Ina May Gaskin. This maneuver moves the mother on to all fours (hands and knees). Ina May stated, "Once we adopted the use of the all-fours maneuver, there were no injuries to any of our shoulder dystocia babies." It is shared that the all fours (hands and knees) maneuver "always works" and is "superior" to other maneuvers traditionally taught. The success of this maneuver is truly wonderful, however, it still would appear safest to allow the baby the maximum space for passage prior to the baby getting stuck and trying to resolve it at that point.

Biomechanically, women were not designed to give birth on their back; therefore, it is evident that we should begin by working *with* physiology and biomechanics rather than working *against* them. Past president of the International Federation of Obstetrics and Gynecologists, Dr. Roberto Caldeyro-Barcia explicitly states, "Except for being hanged by the feet, the supine position is the worst conceivable position for labor and delivery." Renowned expert and author, Dr. William Sears, who trained at Harvard Medical School's Children's Hospital states these five reasons not to birth on your back in *The Birth Book: Everything You Need to Know to Have a Safe and Satisfying Birth*: (1) It will hurt mother. (2) It can harm baby. (3) It slows labor. (4) Episiotomy or tears are more likely. And in a pure and intriguing expression of honesty he bluntly states the fifth reason - (5) **It makes no sense**.

Such birthing positions do not allow full sacroiliac joint motion to occur and place most of the woman's body weight squarely on her tailbone, forcing it upward and restricting it from freely moving backwards as the baby is trying to pass through. Recognized pioneer of natural childbirth, Janet Balaskas shares, "In the semi-reclining position the sacrum is immobile and the pelvic outlet narrows...when the mother squats, the sacrum is free to move... The acrococcygeal joint, the joint between the sacrum and the coccyx or tailbone, also softens in pregnancy; it is designed to swivel backwards to widen the outlet of the pelvis as the baby emerges. Of course, this is impossible if the mother is sitting on her coccyx." If birthing mothers were not put on their backs (semi-sitting or dorsal lithotomy positions) in the first place, there would be significantly less babies getting stuck, less trauma, and less injuries to babies and mothers as well.

Having your precious baby injured for life, before he or she is even born, is truly heartbreaking. But having your baby endure an **unnecessary** and **preventable** lifelong birth injury is a true travesty, and enough to make any parent grieve perpetually. This injury requires relentless effort and commitment on the family's part. Battles with insurance, fighting for needed services, enduring a stressful litigation process, hours of daily home therapy performed by mom and dad, emotional stress, financial stress, relationship stress, multiple weekly therapy appointments outside of home, appointments across the nation to see BPI specialists, surgeries, etc.

For individuals and families dealing with this injury, support, accurate information and timely referrals to specialists are all crucial. I currently serve on the board of directors for the United Brachial Plexus Network (www.ubpn.org). The United Brachial Plexus Network (UBPN) is a registered non-profit organization devoted to providing information, support and leadership for families and those concerned with brachial plexus injuries worldwide. I am also the President of In-Reach, Arizona's brachial plexus injury support network, which is composed of children and adults who have sustained brachial plexus injuries. In addition, some of us mothers and fathers with children needlessly injured for life at birth aspire to come together to do something about all these preventable travesties, especially those related to potentially unsafe routine protocols, such as on-the-back positioning and immediate/early umbilical cord clamping , which my son also endured without my understanding of the possible harmful implications. We are hoping to be joined and supported by various courageous professionals who are committed to ethics and care enough to make a difference for mothers and babies.

It is imperative that all expectant parents inform themselves regarding safe birthing and how to prevent unnecessary injury to the baby, and to the mother's body as well. A great book regarding positioning is *Sit Up and Take Notice! Positioning Yourself for a Better Birth* by Pauline Scott. I regret everyday that I was not better informed. I now know there is no medically sound reason to give birth on your back, and there is every sound reason to give birth in a safer position that works with female anatomy and physiology, and does not restrict the pelvic outlet. Had my medical provider or I been educated and informed about the biomechanics of the female pelvis during birth, my precious child could have been spared from an unnecessary lifelong injury. I would have worked *with* physiology instead of against it, and by no means would I have ever risked closing my birth canal by up to 30%.

As a mother, you do everything in your power to protect that little miracle growing inside of you for nine months. It is truly devastating when the health of your baby is taken away, when you as a mother could have done so much to protect that baby and ensure his or her safety during delivery. It just hurts so deeply. Had I known what I now know, I could have also spared our family of the stress, grief and heartache that this injury has brought to all of our lives.

In conclusion, I must express that the practice of obstetrics can potentially be nothing shy of miraculous. There are many, many wonderful medical providers out there, and the field of obstetrics certainly has its value, and for that we should be grateful. However, medical providers must recognize when particular protocols are not in the best interest of mothers and babies, and they must be courageous enough to change them accordingly. It is imperative that medical professionals be willing to objectively challenge the deeply engrained belief systems that the medical establishment has perpetually imposed upon them.

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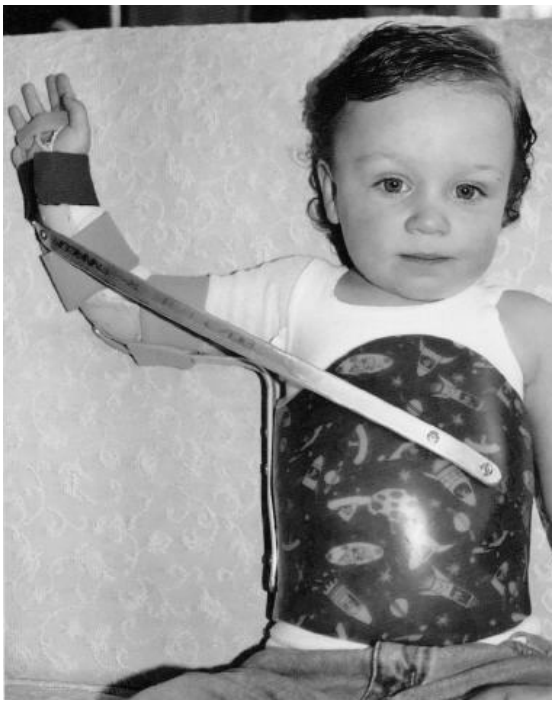
If there is one thing that we should all agree on, it should be that there is NOTHING more precious in this world than a newborn baby, and there is NOTHING more important than the safety and health of that baby. Physiological and biomechanical facts of birth do not cease to exist just because physicians and medical staff, or their teaching institutions, choose to ignore them. When acknowledging the clear discrepancy that exists between some traditional delivery practices and scientific fact, in addition to the professional and ethical obligation to first and foremost "**do no harm**", wouldn't it behoove the medical community to embrace new position protocols for the safety of the mother and baby?

Figure 1. Two-year-old Tanner wears a cast for 5 weeks following muscle/shoulder capsule surgery. Due to deformity of the shoulder joint and internal rotational contractures, the cast was positioned in an externally rotated position so muscles heal in a lengthened position and humeral head would be properly positioned in the shoulder joint.

Figure 2. After the cast was removed, Tanner wore this splint for 8-weeks making sleeping most difficult and uncomfortable.



Thankfully, (as Don Ford once said) "truth is a child of time." For the sake of our children and the precious lives that are at stake, isn't NOW the TIME to acknowledge the truth that traditional hospital birthing positions are disadvantageous to both mother and baby, and are potentially quite harmful and injurious? Physiologically effective and safe positions that fully open the birth canal and utilize the important benefits of gravity, not only contribute to lower risk of shoulder dystocia and brachial plexus injuries, but reduce the potential for other injuries and complications as well.

Figure 3. Shown here is a "Dynasplint", or dynamic/tension splint, which applies pressure and stretching to Tanner's arm all night to help with his elbow/bicep contracture. His arm is permanently bent/locked at about 25° or so. Tanner will continue to use the splint until around 18 years old (when he stops growing). Without the splint, his contracture will worsen and he will lose more range of motion. The other night Tanner started sobbing in bed and his mother asked, "What is wrong?" Tanner replied, "This splint doesn't help me cuddle with my teddy bear." Tanner was not the only one in tears that night.

Figure 4. Tanner is shown during a 20-minute electrical stimulation treatment, administered 3 times a day, everyday, from the time he was 5-months-old. For the past year and a half he now wears a different unit at night underneath the Dynasplint—of course, if he does not tear it off!

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Unnatural vs. natural birth experience: two widely different outcomes

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Abstract

I have two children with autism and as is the case with many others, I was first shocked to learn that it was very possible that my children were immediately cord clamped into autism. I believe, after some investigation into the matter, there are many roads to autism, but there are gradations, timings, and events that all play a role in this outcome. Perhaps all these timely events contribute to the reason we have a current autism epidemic.

There exists substantial evidence that autism can occur in children who have been immediately cord clamped, birth drugged, and or c-sectioned. Damage occurs through hypoxia (depletion of oxygen) which occurs due to interruption of placental transfusion at birth. This can cause a dampened response to environmental stimuli such as vaccinations or drugs used during birth, iron deficiencies, hormone loss, enzyme loss, stem cell loss, and deprivation of other immune factors in cord blood which essentially make the child subtly injured or major damaged. This, in turn, damages areas of the brain which are highly aerobic, such as the inferior colliculus, or speech centers, even affecting the superior/inferior olives and brain stem nuclei. When this damage occurs in monkeys, they act autistic and parallel damage in the brain is seen.

Keywords: natural childbirth, cord clamping, birthing drugs

My story begins with my son, my firstborn. While in the labor room, I was offered Pitocin to speed up an already 24-hour labor which was not progressing, But I refused. Something inside me said, "No, don't rush this." But I was in severe pain, and the previous day I had had a terrific migraine. The physician ordered Pitocin of which I again refused. He then offered me Demerol—which I accepted because I felt that it was only a painkiller. During this time, a monitor that showed my unborn baby's heartbeat was going all the way down to zero in my room. Without a doctor coming in to check on this, I was very concerned and called the nurse in to inspect the monitor. She tapped the machine and it began to essentially "work again." So, as it progressed after another two hours, it was time for my delivery. We have only 8mm pictures of the delivery in rapid succession. I was put on my back of course, and feet sprawled into the air. The baby came out, and there were immediately scissors, knifes and what my husband called insulation cutting of my entire birth floor, and clamps going, and the baby was instantaneously on my stomach. Visually, I could see a noted blueness in his hands and feet. Interestingly, the Apgar scores were not given to me until the blueness was alleviated. The doctor said "8" but I did not believe this number to be correct nor necessarily the product of solid science.

I had two children (both girls) between my first son who is autistic and my youngest daughter who is autistic. The 2nd and 3rd children had much different outcomes. Their deliveries were more "natural" and I was sitting up a lot of the time backwards on the bed. The theory here is to let gravity do the work for you and this position is great for relieving back labor. This facilitated an easy delivery with no birth drugs used.

I did have a worrisome time with one of the two however with showing of meconium, but this involved a larger baby and the concern was resolved quickly. Both are normal children, though the one who had the merconium does have slight ADD.

Then my last (fourth) baby I had precipitously, almost in the parking lot where the baby began crowning. I barely made it to the hospital where I was put on a bed. I didn't know what was happening, and within a half hour gave birth. The baby had little to no muscle tone. It seemed to me she was as a rubber band coming out. The nurse almost dropped her and rushed her immediately to the nursery, probably to jab her with Hep B, and called the delivery "precipitous."

There were no visuals shown to me indicating how my newborn girl was doing, and there was no time given to me to allow counting all fingers and toes, etc. There was immediate clamping of the cord. Also, 8 mm rapid succession pictures visually demonstrate that both of the children (the 1st and 4th) with autism were blue.

It is an unusual circumstance to have a boy and then a girl with autism with two normal girls in between. Autism normally affects males. Another important factor in both of the pregnancies resulting in autism was that I had an illness that I treated with antipyretics. With my autistic daughter, I had a simple STREP infection which required repeated antibiotics; however, with the other two girls I was never sick. My son was administered the DPT vaccination which caused a reaction with high-pitched screaming 11 days later. After my daughter received her MMR vaccine, within two weeks she had autistic enterocolitis symptoms.

I was not offered Pitocin obviously in her case. Often, as in the case of my first child's birth, Pitocin is offered under duress. This makes the policy for immediate cord clamping a given. As to the Demerol, evidence does support that use of this drug is associated with increased risk of autism cases. Many of the children had billirubin problems, as well as insulin problems at birth. These are, I feel, direct evidences of a problem at birth. The theory is that insulin is also robbed during the birth process or while the mother is pregnant and having some form of insulin insufficiency during this time is a sign that the mother is mercury or iron toxic already.

I have to wonder, why these children with noticeable blueness in hands and feet, and precipitous delivery upon arrival to

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the birth hospital, and drugged, are now autistic? I have to wonder really, if it is genes or vaccine reactions? The children became more autistic with every successive vaccine they received. Even at birth I noticed that the children were not sleeping, they had hypotonia, were cranky, later refusing solid foods, loss of eye contact which worsened after more mercury-containing vaccines. Or is it their birth and the procedures and interventions employed that contributed to this outcome?

In my estimation, a combination of these factors could have been involved. Why are mothers being detached from this experience of giving birth. To be no longer in the driver's seat when birthing one's own child is beyond me. Most mothers I have talked with had complications during their pregnancy, were offered various drugs, and or had even worse experiences—such as cord around the baby's neck etc., even though apgar scores went up after 5 minutes following birth.

We know that oxytocin and chlorobutanol, are thyroid damaging drugs and go to the breasts, contaminating the mother's milk. On top of that, I wonder why thyroid hormone is decreased in these children, or malfunctioning and/or their oxytocin/vasopressin measurements are not within limits! Also antibodies against serotonin are skewed.

These factors cause the brain to grow at faster than normal rates which is commonly seen in children with autism. Ater all, oxytocin is a drug of abortion, and the visual they see in abortion is that the brain essentially "blows up via severe damaging inflammation." Additionally, the Hepatitis B shot with mercury causes this neurotoxin to affect the brain because the BBB (blood-brain barrier) has been breached. On further examination, the colliculus and brain stem are damaged. Asphyxiated monkeys with these areas damaged in their brains act autistic.

Later what came to light is the fact that our children have iron regulation problems, appear to be anemic, when in fact they are iron loading in the monocytes. They also appear to have autoimmunity against their red blood cells. These occur in many instances as a problem with an ongoing infection or a triggering event after an oxidative stressor has occurred. So, one can surmise that iron regulation is controlled by the very birth process which robs them of available iron.

Furthermore, other scientific literature available from MEDLINE show, that DPPIV is in cord blood! This is a very key enzyme needed to break down milk and wheat proteins, a huge problem in autism. And, the fact that you are oxidatively stressing the brain, which calls out the iron troops, yet no iron is available, is a concern. Hormones, said to be skewed in autism, are always at improper levels. There is evidence that high testosterone in male infants make them more vulnerable to heavy metals in vaccines. Enzymes, needed to do molecular energy cycling, are also unblanced in our children. There are just too many things known about the biological mechanisms that are taking place at this vulnerable time in the life of the infant, especially when these natural processes are not allowed to reach their natural completion, simply to label the problem as genetic.

In my children, what has been diagnosed as autism, is really the result of immune dysregulations caused by numerous events that oxidatively stress the body (including mercury in vaccines and having less immune materials delivered to the child in a timely manner at birth). Autism is also the result of metabolic mitochondrial disorders caused by oxidative damage, leading to the possible increased risk to the child of vaccine injury. Another factor in autism is birthing injury caused by early clamping, Pitocin and other birth drugs, demerol, even aspirin offered to the mother while breastfeeding, etc.

Now that I am aware of these events, my marriageable daughters will know that they must find a knowledgeable midwife or supportive birth center and a binding contract to make sure that poor medical practice is not performed on their babies. Use and incidences of C-sections are huge in the autism community. There is a need to question and investigate all possible causes of autism and not just assume this outcome is purely genetic.

A current theory behind autism outcomes is that testosterone makes the male infants much more susceptible to heavy metal toxicity, and estrogen seems to counterbalance the effects. Also important is metallothionein levels and how this oxidant is used more readily in an estrogen-dominant (female) system. Glutathione also likes estrogen influences, rather than testosterone. So both glutathione and metallothionein are very important for our children, especially because they are either missing or not found in sufficient abundance in a given infant. Guess what is in cord blood? You got it, glutathione and metallothion. If these children have a susceptibility gene it is the polymorphisms of MTHFR and glutathione perixidase and metallothion, as is a similar case with children manifesting cystic fibroses. They, too, lack the same, as do the children with Down's Syndrome and those with ADD. That is why all these diseases demonstrate essentially oxidative stress states.

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Fraudulent and bogus medical policies, procedures, and protocols involving active management vs. natural birth tradition

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Abstract

Today, pregnant mothers know little concerning the past birthing experiences of their grandmothers. There was no fear of invasive laws prior to 1920 when woman gave birth as nature allowed, unassisted on the farms of North America. Such was also the custom of my grandparents who gave birth to blue-ribbon babies. Coming from rural farms in Canada, my parents (mother born in 1913; father born in 1914) had strong immunity due to the fact that my grandparent's generation waited for all blood—including the immunologic protection and nutrients it contained, all hormones and enzymes—to pass from the placenta to the newborn.

Today, this practice has been supplanted with what is known as immediate cord clamping (ICC) and various forms of early cord clamping (ECC). The obstetrical practice of ICC or ECC jeopardizes the newborn's brain and other organs by interrupting placental oxygenation and placental transfusion during the transition from fetus to newborn. The child is compromised with as much as 50% of blood volume remaining in the placenta. The newborn requires this blood to expand its lungs. This blood is also needed to adequately perfuse all of the baby's cells and organs. All causes of autism are not known; however, cord clamped babies would likely be found to be at higher risk than those not clamped or delayed clamped. Interestingly, the ICC procedure became apparent after the typing of the blood in 1901 and continued as markets opened up for the placenta blood, cord, membrane, and stem cells.

Keywords: natural birth, immediate cord clamping (ICC), delayed cord clamping, infant rights, medical malpractice

My developing hypothesis

I am a mother and grandmother who started my personal inquiry into life about 1998 due to a nagging feeling — an intuition — that *something* was responsible for causing all the learning and behavior problems common today. Why are there so many experiencing severe allergies, and low immunity with higher risk of cancer, and brain cancers in youth?

My interest became more intense in 1999, when I was among a group of four women enjoying tea after an art-sketching class. During our casual discussion, one mother brought up how pleased she was that her teenage daughter had completed high school and was touring Europe before returning to Canada to become a veterinarian. The story was most impressive because the daughter had suffered a severe brain injury as the result of an accident on a farm. But the child's "will" was so keen, nothing would prevent her from her goal. She has accomplished her goal and today serves as a veterinarian.

At hearing about the "will" of her child, I shared my view that I believe many of the learning problems found in children were being caused at birth by immediate umbilical cord clamping, and the related issues of depriving children of nutrients, blood and oxygen.

Based on my raising two very different children, I was forming a hypothesis. While not wanting to compare them, I could not help but notice that one child had learning difficulties not shared by the other. The only difference was in their births: the child having learning difficulties had received morphine through my having accepted Demerol without being informed of its effects. As a result of taking two such pills, the newborn was immediately cord clamped, and was jaundiced at birth.

Initially, I could not understand how my parenting skills along with the teachers' efforts failed this child so completely. Despite appearing normal and being highly active and physically able following birth, it became clear later that my son had learning problems.

By contrast, my other child could learn in any environment—even in those not usually conducive to learning. While my daughter proved very capable in her studies, my son found it difficult to advance with his peer group, and only learned to read after age 13. Why did he, and not my other child, experience sleep and eating disorders? What delayed his abilities? Why couldn't we deal with his needs more effectively?

Via the Internet, beginning in 2000, I touched bases with many concerned fathers and mothers, most of whom had a compromised child that added to the burdens of life, and who had similar questions.

Returning to that casual discussion, after I finished relating to the group my theory concerning compromised children, one of the other mothers revealed she had formerly served as an obstetrics nurse. She shared my concerns about iatrogenic-caused impairments due to early umbilical cord clamping. While in the nursing profession she had always worried when doctors did early cord clamping of the babies. Her personal observation was that many of these infants did not breathe quickly on their own, and were not always easily or quickly revived.

However, she did not feel the same concern when doctors waited until the cord had completely finished pulsating—no matter how long that took—before clamping the cord. In the Operating Room (O.R.), she noticed one doctor that always did delayed clamping, and she compared his positive results with

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the lackluster babies delivered by another doctor who always did immediate clamping.

I asked her whether some doctors were doing "occupational control" and were choosing which babies would be early clamped, according to a bias of sex, or color, or race? The nurse said, "No." She believed, "the method and manner used by those doing the training, and/or the material from the textbooks dictated whether the trained and licensed doctor performed either immediate or delayed clamping."

This former obstetrics nurse indicated that there were never any long-term follow-ups with the mothers and children. No one was properly researching the consequences of administering drugs and doing immediate clamping, nor collecting data on outcomes of those interventions compared to the life quality of babies born with no clamping or with fully-delayed clamping and no drugs. She shared my suspicion that many of the children who have pain, and who must struggle in school, are most probably those who were damaged during birth due to hasty clamping of the cord. If proper data collection and analysis were to be done, I would expect to find more confirmation of this hypothesis.

In Our Grandparents' Day

Our ancestors were most wise not to tie or cut the cord while the placenta was yet in the mother's womb. This avoided risk of contamination, such as by a virus entering through the cut cord and into the bloodstream. They did not know at the time—and likely would not have cared about—all the microbiological details of how the child received all the immunities of the blood, all nutrients, all hormones, and all enzymes. The wisdom in allowing all blood from the placenta to infuse into the infant was demonstrated empirically in their vigorous babies growing up to be capable adults.

I was age 14 (see picture) when I learned from my best girlfriend that our grandparents did not tie or cut the cord. Rather, and wisely too, they left it alone and put the placenta in a diaper. They waited for the umbilical cord and the placenta to fall away naturally. Within a day or two of birth, after the cord had detached from the umbilicus on its own, the pioneers put lime on these by-products of birth and buried them in their own yard.

Back then, I thought to myself, "How gross! When I have a child it's going to be 'state of the art'." Little did I know that this squeamishness would later cause so much difficulty for me and my first baby.

My First Delivery Experience

Thirty-six years before that pivotal conversation with other mothers, I had birthed my first child. My water had broken the evening before, and the doctor said to go to the hospital that night. I followed his instructions. There, I was subjected to the doctor's policy of shave and enema. All women had to experience that degradation.

I had expected the doctor to see me that morning. The second shift nurse came on shift at about 7:00 a.m. At about 8 a.m. and while the doctor had not been in to see me, she offered to give me a pill to take the edge off labor discomfort. I inquired if it would harm my child. She said, "No, it will make the labor pains less severe." I accepted. I found out later that the doctor was delivering another baby at another hospital. In my research I would discover that nurses generally do not offer medications in hospitals unless suggested by the hospital or the doctor. I found in my research, 1998 to the present, that Demerol, a morphine, can be given to mothers by midwives, too. It is known to slow or delay labor in the mother and to cause jaundice in the fetus/neonate. Had I known that, I would have refused it. At this time—during my entire stay at the hospital—I had had no food, no water, and was confined to bed—flat on my back, with the baby mal-positioned. The labor stopped. I believe the primary reason I was offered the pill was to allow the doctor time to manage another's birth, and then see office patients before getting around to me. That was a financial decision to *his* benefit and not for the benefit of *me* or *my fetus/child*—his patients.

The doctor was busy from midday to late afternoon with his office patients, so I was offered another pill at mid-afternoon. This continued to delay my labor. This was the new state-of-the-art method to delay labor; the previous method involved tying the mother's legs together. In this way doctors arrived in time to catch their fee, I mean the baby! Finally, when the doctor had the time for my birthing child, he came in at his convenience after 3:30 p.m. and my delivery commenced, including a routine episiotomy.

I almost lost my life. First, the doctor had me climb on a high narrow table from the bed I was in. Fortunately, "Attila the Hun" was on the other side and prevented me—given the drugged state I was in—from going over the side. Had she not been in that position, I would not be sharing this birth rage experience today. For this I give her thanks.

When my child was born, he was not crying. He was a very drugged baby. I had no indication he was alive or dead since he was not immediately shown to me. There were no mirrors set up for my observing my child's birth while in a flat-on-the-back position. The doctor and the nurse had put my son to the left of my side and were doing things to him that I could not see.

Being influenced by pop-culture ideas of childbirth, I asked the doctor if he was going to do the traditional tapping on the child's feet, his head down? He then did so, after saying, "Oh, you meanie, you!" but then the child began to cry. Having seen that he had all his fingers and toes and was now breathing, I drifted off to sleep.

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I was wakened some hours later by Attila the Hun. She ordered me up from the bed in which I was left inclined upright. I said I felt sick and did not think I could get out of bed. But she insisted and helped me and I immediately fainted. Had I not come to within the expected time limit, I would have been shocked awake. She was holding a glass of cold water, and said she was ready to throw it on me.

Since I had a living child I thought I had no right to complain, despite the fact that he was so yellow that everyone remarked what a cute Chinese baby he was. He was not the slightest bit Chinese. His father and I are both Caucasian. But that is the effect of drugs on the system of an unborn child. The infant's liver and kidneys get overloaded by drugs given to the laboring mother. I assumed that was the way things were normally done.

I considered my treatment mild but, nevertheless, it amounted to a breach of the trust and care I expected. Apart from my rage at my first-delivery memories, I consider myself fortunate to have gained from the experience of the kindly Chinese lady in the bed next to me. This sweet lady was having, I believe, her 5th child. She begged "Attila" not to shave her or to give her an enema. She pleaded, "my babies come very quickly, this one is on its way."

But Attila the Hun said it was the doctor's rules. Then she picked the little Chinese lady up and walked her to the washroom. There I heard a scuffle and the nurses were flying for pillows. The baby had been born on the floor. I never saw that nice Chinese lady again. I was told she left the hospital with the baby and went home. Perhaps she did, escaping thereby many interventions and humiliations.

My first-born child had many latent difficulties that did not become apparent until he was left behind in reading and general school accomplishment. There was a system of "peer passing" in the public schools—moving all children forward with their age group—that was concealing my son's problems while allowing him to fall farther behind. This was unfair both to him and to us his parents. I see a connection between the drug used during his birth, the early umbilical cord clamping used as a consequence, and his problems in school. His difficulties became obvious to me when I noticed his three-years-younger sister able to do work that he could not do himself.

Other parents had similar problems and were also wondering why Johnny and Jane could not read. Why many children had learning problems and needed individual help, private schooling, tutoring, and special home schooling has still not been attributed to the drugs offered and accepted during the third stage labor, nor to the timing of clamping off the child's pulsating cord. Like the other parents of such children, I had never associated his problems with birth drugs and the ICC that followed.

Now, thanks to my research, I know better. In 1965, Dr. G. W. Roberts attended to my first child's birth at Mount St. Joseph's Hospital, Vancouver, BC. The policy of this hospital included sending the father home, confining the mother to bed, and imposing by the doctor's instructions, enemas and shaving on the woman. No telephones were available to the birthing mothers if they needed to call for help from spouse or relatives.

During delivery the mother was to be flat on her back for the convenience of the doctor to "catch" the baby, no doubt, much like a football receiver catches a ball. In this worst-possible birthing position, the woman has little control over her own body. Granted, it is very convenient for the doctor to stand comfortably upright while performing an episiotomy and pulling the child from the womb with forceps (potentially leading to many serious consequences to the child, including risk of infection to the woman's body by the cutting and the stitches then required).

I did not give specific consent for the doctor to perform an episiotomy, nor did I give informed consent to take a drug that I was never told would cross over the placenta, risking harm to my child, poisoning his system, and causing birth jaundice.

In my case, "active management" used to perfection: first using drugs, lacerating the woman's perineum, then taking the baby off its life-line and out of the mother's view, so that she could not know what was being done, or even whether her child was living or dead. Perhaps Dr. G. Waldon Roberts is entitled to a rebuttal to tell of his training. I would like to hear him explain why he postponed the birth of my child for his own financial benefit that included two deliveries and a full day of office patient care.

Is that what doctors are trained to do? Exploit the use of drugs to delay the progression of labor, with the water already broken the prior evening? That is exactly my perception upon reflecting on this first birth experience. Does that make my child an inferior person? No. But it did make life more difficult for him, and he could not compete with those of his peer group that were not drugged or victims of ICC.

My Research goes into high gear

In the light of such memories, the obstetrics nurse's revelations stimulated me to take on the entire medical system. I began more earnest letter writings to the College of Physicians and Surgeons of British Columbia. Their reply was supposed to reassure me that my hypothesis—impairment of children by clamping umbilical cords too early—was unfounded. They said, "All doctors were trained not to clamp the umbilical cord until all pulsation ceased."

However, by April of 1999 when they wrote that letter, medical policy had already abandoned that logical principle. I learned that as early as December 1998—four months earlier—the Society of Obstetricians and Gynecologists of Canada (SOGC), in Policy #71, permitted routine early umbilical cord clamping at only 30 seconds after birth. While admitting that the child was deprived of 20 to 50% of his or her total blood volume and the resulting anemic conditions could result in two weeks' to six months' setback for the infant following birth, the reason given for interruption of the infant's lifeline was that the procedure shortened the time period of the third stage of labor—the birthing of the placenta.

Though knowingly endangering the child, with Policy #89 dated May 2000, the SOGC went further, directing that immediate cord clamping (ICC) be performed on all babies. The reasons now given for this even worse policy change concerned the performing of a pH cord blood test by "instant" or "immediate" interrupting of the circulation of the child. Thus, although safer options were known to be wiser, interrupting the circulation of the child became the medical standard.

Already in 1998, Obstetrician and Gynecologist Dr. George

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M. Morley had challenged the ACOG's education committee to make a public retraction of this policy. He shared with me his view that by inserting a very fine needle into the artery or vein, a small sample of blood could be obtained. Therefore, the test could be done without interrupting umbilical blood flow.

Personally, to avoid any chance of an airborne virus getting into the bloodstream, I prefer that not even a tiny needle be inserted into the cord. In the "Lotus Birth" protocol, all injections into the baby's body, or cord, and all withdrawing of blood, are to be avoided in those crucial first few minutes while the baby is pulling in all circulation from its temporary external storage. If a medical need arises, any tests should take place *after* the full infusion of the baby's blood into its body and lungs. This will equip the infant better to resist infections and to withstand medical interventions.

I have written to the experts and they fail to address the issue. Do the obstetrics authorities fear that if they admit the truth about the baby's need and right to be topped up with his own blood, civil and possibly criminal charges could arise from the policies they allow to be practiced? The older and wiser doctors of bygone days, who had visual knowledge of what remains in an engorged placenta, are now retired. Little medical dissent from this bogus policy remains. SOGC's reply to me was dismissive, "We are aware of your concerns. Thank you for writing." That was all.

In Canada, Politicians at all levels of government—local, Provincial, Territorial, and Federal—were conspicuous by their inaction. Not one has investigated the timing of the cord clamping. Despite all their rhetoric against rising Medicare costs, not one considered a direct link between ICC and the synchronous rise in internal disorders requiring high-cost treatment and specialized, expensive educational services for the youngest generation: learning and behavior disorders, increases of autism, brain lesions, SIDS and other deaths. Many such cases may be preventable if a little patience was exercised in delivery rooms, and primal births were allowed in all hospitals and birthing centers.

The rushing of deliveries for the sake of "efficiency" is clearly a false economy imposed by hospital budget cuts. In contrast, improved vigor of babies allowed their full blood supply would reduce subsequent health-care costs significantly. In the USA, the $200 billion health budget could be reduced just lowering the rates of internal disorders related to kidney, liver, heart, lung, and brain disorders, which could all be occurring so widely because of low immunity based on blood deprivation at birth. Health cost savings would be similar in every nation that that currently uses "Active Management".

So why do hospitals fail to apply the obvious preventive measures of allowing the baby to thrive with its own resources intact? Why do they ignore informed consent and primal-birth rights? One reason might be the unholy partnership between politics and private health businesses. Both are seeking to increase profits, which can mean "repeat business" for those who are political—meaning for profits. We are seeing growth in non-profit societies dealing with damaged children, *not seeking prevention*. Compromised children are developing into spin-off businesses for many walks of professionals. Might it be as simple as that?

Financial cords that bind

When medical policies ignore visual and scientific evidence of harm to babies, and procedures seem to be used as an excuse to exploit both the mother and child, and these practices are approved for political reasons, we have to conclude that the responsible authorities value profits more than lives.

In our day, business rules of "efficiency" and "cost saving" are being applied indiscriminately, as if maternity hospitals were factories and as if babies were so many widgets. Doctors are business people. Unscrupulous business attitudes can lead them to do what is most convenient and efficient for them, rather than what is best for their tiny patients. So manipulating a woman's labor by drugs, called "active management," comes easily to economist-influenced doctors. When we add to the picture the fact that many doctors are paid fees for services, rather than a fixed salary, we can see that there is an added motivation to perform as many procedures as possible.

The amount of blood created for the infant's own needs at the time of its birth is crucial. On page 324, Volume B, of the *World Book Encyclopedia*, 1979 edition, it states "… a 9-pound (4-kilogram) infant has only about 10 ounces (300 milliliters) of blood." That is the total blood volume; there is none to spare by deprivation of 20 to 50% of a child's total blood volume due to early cord clamping. In fact, a case law precedent, the Chow case (Ontario, Canada) stated very clearly for judgment reasons that a 20% blood loss can cause any person to go into shock.

Mothers should be cautious of signing hospital contracts that state that tissues—organs, placenta, including cord, blood, and membrane—will be "appropriately discarded." This wording does not guarantee that these products will not be sold to third parties for use in other patients. The business side of medicine is "self-regulating" with apparently no accountability to the public, including to our newborn citizens from whom they take the tissues and blood to be sold, without consent. (see Table 3, John Moore Case-Law).

The Federal Government allows use of human blood and organs, but unfortunately fails to provide a system of checks and balances on lab technicians and other medical persons, on blood banks, organ banks, and tissue banks, on research institutions and on drug companies.

The placenta is valuable to the cosmetics industry as well as to various drug companies. The blood contains hormones, enzymes, white cells, red cells, platelets, and plasma that can be separated. Each of these separable substances is marketable with its own dollar value. These facts are never shared with the parents-to-be. The fee paid for the service of taking blood samples is not negligible. To cover the costs of handling, a doctor or nurse in charge of wastes may realize approximately USD $250.00 per 50 cc of blood sent out. The taking of 200 cc (equal to 200 ml) of blood from a very large 10 to 13 pound child—likely a c-section baby with immediate cord clamping that is standard practice in this situation—means that there could be as much as US $1000 paid to the person doing the collection.

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Legal implications

The lack of investigation means that the government already knows about, and apparently approves of, practices which amount to commercial misuse of the public institutional care facilities where babies are born. Private cord-blood banks receive the majority share of the baby's blood products, sold for profit. The truth is that any hospital allowing clamping off a functional umbilical cord from the placenta—an organ used to assist the volume and pressure of the infant's blood being infused into the baby's expanding lungs—is both negligence causing bodily harm, and (in effect) trafficking in stolen blood—stolen from a defenseless infant.

Ethics committee policies at each hospital often reveal that once the infant is deprived of the placental blood, the doctor leaves it to be "discarded"; i.e. the doctor gives the hospital free rein to do whatever it wants with the blood. In other words, the hospital "discards" the placenta and its contents in the manner *it* deems fit which entails recovering blood and tissues for sale—without any benefit or compensation to the unwitting and unwilling newborn "donor" who is too young to assert his own rights.

The placenta is the child's own organ and contains the child's own blood—DNA will prove that fact. The blood contained in the placenta and umbilical cord is therefore the *property* of the infant, and belongs to no one else. The infant's property rights are violated if this blood is taken without the consent, or even the knowledge, of the parents. Who has the fiduciary responsibility for their newborn? The parents, or the hospital?

The ethics committees across Canada, in the United States, and abroad, are overlooking if not outright approving and setting medical procedures that are unsafe and contrary to the public's best interest—which coincides with the infant's right to optimal health. Most such committees in hospitals seem to be totally in the dark about the ethical implications of early cord clamping, the volumes of cord-blood being sold. But ethics committees or no, hospitals make sure they get control of all cord-blood and profit from its value in stem-cell research.

Who is responsible?

Hospitals today often send anemic babies home with the parents. Is this doing their duty as professionals at the hospital or birth center? Why do they cover up (1) the amount of blood drained out of the placenta, (2) the name of the third party that might have received the placenta, cord and membrane, and (3) the amount of blood taken for use by others? Why do they fail to serve the interests of the infant, the actual "owner" of that blood? When child endangerment occurs, whose duty is it to report this?

The doctors have no "good" excuse to hurry up a birth, to interrupt a functioning organ that would in a brief time infuse up to 60% more blood into the baby's expanding lungs. They have had no good excuse to destroy evidence, or fail to report the condition of the cord when clamped, or the position of the child's body when clamped.

Officially the problem is swept under the carpet. Contrary to the fact of shock due to blood volume deficiency, Dr. Gabbes of *MDConsult* states the opinion: "The amount of blood left in the placenta is not important, in most instances." To allow the child to have the best chance to reach its own potential genius, the duty of adults is not to take one drop of blood, let alone create an interruption that can stop up to 60% of total blood volume from reaching the infant. This is known and stated in the World Health Organization's references of over 100 such facts, and is reiterated in a well-known edition of Lippincott's *Nurse's Manual of Practice*.

As I see it, the clear duty of the health-care professional is to allow the owner/infant to have every last drop of blood from a functioning (or would-be-functioning if not interfered with) umbilical cord and thus allow the baby to be as strong as nature intended. To create and follow policies that result in weakened, anemic babies will have to be seen as malpractice.

Coroners refuse to investigate premature-baby deaths. Why? Because it is professionals who attend births, such as medics, doctors, and nurses, their reasons are accepted as legally valid. Therefore, "natural causes" is assumed and recorded as the cause of death. The idea that early cord clamping—done as a matter of policy—is medical malpractice and should result in criminal investigation never crosses any coroner's desk or mind.

Babies have no obligation

Therefore, it should be the duty of all healthcare staff not to exploit the child by taking this blood without consent to provide raw material to treat the sicknesses of others. The babies have not caused others to be sick. They have no duty or implied duty to be imposed upon to give blood to a sick relative, mother, sibling, or stranger. Nor is it right or necessary to have their blood—needed for their immediate and ongoing well-being—to be stored for hypothetical use at a later time.

Primal Birth Rights

Making primal birth the standard of practice would eliminate the legal quagmire resulting from "active management". However, medical persons today either know nothing about primal birth methods, or are indifferent to their importance for mothers as a female-human right.

These include: warm water births, gravity births (not flat on the back or semi-sitting birth positions), no mechanical devices imposed on the mother or the child, no drugs administered to the mother, no clamping or cutting of the cord, no injections to the child, and privacy in the birthing room with only the mother's approved birth witnesses present. Last but not least, all mothers must be free to exert their right to exclude professional persons, unless they are invited to handle the few unusual conditions that might require such intervention.

Ideally, the rights of the birthing mother inside the hospital, should be the same as her rights outside the hospital:

- freedom to assume gravity-assist labor and birth positions (no supine or semi-sitting positions that close off the birth canal)
- freedom to consume food and fluids for increased energy and maintaining hydration
- freedom to access restroom when the mother chooses
- privacy in birthing room with only those assistants chosen by the mother, and right to exclude professionals except those invited to deal with any anticipated difficulties

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- freedom to refuse drugs for herself based on full information, and no injections given to newborn
- right to decline medical procedures and mechanical devices as defined under "active management"
- no clamping, cutting or interference with umbilical cord

It is suggested that, with the mother's consent, a video camera be used to record all steps of the birth until placenta delivery, for C-section babies and vaginal delivery both. No doctor can object to the camera: filming procedures for educational purposes is an approved policy. Therefore, videotaping the birth of every child is legitimate to confirm that all things were done decently and in order, according to the birth contract/waiver.

The issue of ownership of the placenta and placental blood has yet to have its day in court. This must happen if we are to stop the use of fraudulent protocols and procedures used in birthing hospitals. Millions of children have already been negatively affected. The medical practices and secrecy casting long shadows over our young sons and daughters must be brought into the light and exposed for the problem to be corrected. I have just learned that the grandson, Kevin Sorenson, of the midwife who helped with the delivery of my mother in 1913, is now an elected member of Parliament (MP) of the Federal Canadian Government, representing the Crowfoot Alberta constituency riding. I expect to be in contact with him in the near future regarding the Petition: Protect Babies and Mothers, Too Petition (see Table 1).

I stand on this battle cry, "Not one drop of a baby's blood to spare, and not one child to be sacrificed—not one!"

Drug use

"Active management" includes using birth positions that increase the mother's risk and restrict the birth canal, causing more pain and delay and resulting in drugs being administered to "relieve pain". Further, surgical cuts require repair and drugs after delivery. Rates of performing C-sections are rising to over 26% in most "developed" nations. However, only in the rare case of a true emergency—such as when the mother is in an accident, or dies—is there a real need for her body to be ripped open for the sake of the child, compromising her own well-being and triggering the use of antibiotics. During pregnancy there are ultrasound scans and amniotic fluid tests. During birth, injections, early umbilical cord clamping, continued sampling of your child's blood—which involves extracting an additional 10 to 15% total blood volume every 2nd or 3rd day from an infant already in an anemic condition with up to 50% deprivation, plus vaccinations (Hep B), and vitamin K injections.

Generally, healthy "blue-ribbon" babies who receive all their blood supply do not need "active management", or to be injected with foreign matter.

Newborns and infants are being vaccinated against many diseases which they have little risk of contracting. Also, their ability to generate antibodies—which the vaccine is meant to stimulate—is still undeveloped. This is why nature has provided the colostrum—the first milk—which transfers the mother's antibodies into her child.

There is a greater risk to the neonate from the vaccine than from the actual disease. Though the state of the baby's health is unclear when it is only hours old, "experts" can order injections of vaccines based on assumptions, not tests. If, as was likely, an anemic condition was induced in the infant by early umbilical cord clamping, the drug or vaccine will be even more stressful to the baby's health than otherwise.

Thimerosal is used as a preservative in some vaccines. It is neurotoxic in even trace amounts in all age groups, and especially in the infant whose brain is still being formed through the first year of life. While manufacturers have stated that Thimerosal has now been eliminated or present "only" in trace amounts, other preservatives, including the toxic metal aluminum, are currently present and can also cause adverse reactions.

Chlorobutanol, an ingredient found in some oxytocic drugs that are administered to women for "fear of bleeding", has been associated with causing latent thyroid conditions. Oxytocic drugs are associated with heart contraction problems. Use of this drug calls for immediate cord clamping (see Table 2, WHO). The resulting anemia is neither treated nor even identified in most neonates. As a consequence, the mother takes home an anemic baby, unaware of its need for recovery care. Further, she lacks the necessary skills and knowledge. Such a child experiences latent disorders due to the lacking enzymes, hormones, and nutrients of the missing blood. Eventually these deficiencies in blood supply and in external care (through no fault of the parents) result in learning and behavior problems, as well as life-threatening allergic reactions which may be due to the missing enzymes.

Table 1. Declarations and Petitions

Name	Declaration
Buckley, Sarah	Declaration, Part I of II: Don't Clamp the Cord. Dr. Buckley shares her personal experience with home, warm water births, no drugs, and primal birth care, i.e., no clamping or cutting of the cord and cosmetic removal of the placenta. The placenta and cord fell off within 2 or 3 days, leaving a perfect navel and no infections. Available online at http://www.lotusbirth.com/doc/FEB2003Lotusbirth-101.htm
Haire, Doris	Part II, Notarized Declaration of Sarah Buckley. This is the work and research of Doris Haire that began about 1969. Birth Without Borders Conference available online at www.lotusbirth.com/doc/FEB2003Lotusbirth-499.htm The Conference was sponsored by UNICEF in Chiange Mai, Thailand, March 1, 1997. Haire warned all developing nations not to follow Western Society's "Active Management" style. Haire stated, "It is painful for me to report that nowhere in the world has the normal physiology of childbirth been more distorted than it has in the United States. There is growing concern ... as medications, contribute significantly to our embarrassingly high rate of learning disabled children. American children continue to lag behind most industrialized countries in academic achievement, ... as math and science, that require comprehension and deduction. Despite hundreds of millions of dollars spent each year on prenatal care and high-tech maternity care, U.S. schools continue to be flooded with children who cannot learn without special education instruction by teachers trained to work with learning impaired children."
Hodgkinson, Vivian	Declaration update: recently, there has been no serious side effects, despite the broken clavicle, and this is attributed to delayed cord clamping. Other children with similar birth complications, including shoulder dystocia, have experienced serious problems when immediately cord clamped at birth. Available online at http://www.lotusbirth.com/doc/FEB2003Lotusbirth-469.htm Gunther, Mavis (Available online at http://www.lotusbirth.com/doc/FEB2003Lotusbirth-664.htm) Hospital Births: Gunther reported for drugged babies, umbilical cords pulsate for 20-minutes. It is only logical that no babies, whether c-

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	section or vaginal birth, whether premature or full term, should have their umbilical cord clamped, so that circulation and infusion of blood from the placenta into the expanding lungs occurs, resulting in the healthiest baby or babies, possible, as nature designed them to be. Peltonen, T (Available online at http://www.123-baby-birth.com/doc/Nov123%20baby%20birth-342.htm) Institutional births: Peltonen reports no IRDS (Infant Respiratory Distress Syndrome or Hyaline Membrane Disease HMD) when the cords were not clamped until all pulsation ceased. He stated only premature babies with their cord clamped early had lung disorders. Peltonen also reported a documentary medical film indicating heart shrinkage caused to babies whose cords were clamped early.
Petition: Protect Babies and Mothers Too	Concerned citizens from all nations have shared intervention to protect the Canadian Babies now harvested without protest, politically, in Canada. Available online at http://www.thepetitionsite.com/takeaction/102580814
Petition: directs the re-education of US Doctors	This petition not only directs the re-education of doctors, but addresses harvesting the USA citizen babies, without protection of the Senators. Available online at http://www.thepetitionsite.com/takeaction/954816565

Table 2. Significant policies of The Society of Obstetricians and Gynecologists of Canada (SOGC), American College of Obstetricians and Gynecologists (ACOG), and others

Reference document	Comments
USAID Press Release, November 7, 2003	This policy treats "all" women as though they are anemic, and thus promotes use of drugs for "fear of bleeding." It provides no truly informed consent with regard to the use of Oxytocin, Pitocin, Syntocinon, or Toesen drugs after which the WHO directs immediate cord clamping. When WHO directed immediate cord clamping it was conditional if any oxytocic drugs had been given the mother. Thus, they were implying they had knowledge that oxytocic drugs were dangerous to the child's well-being. Available online at http://www.usaid.gov/press/releases/2003/pr031107_1.html More information at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=20789
SOGC Policy #89 of May, 2000	This policy directed immediate cord clamping to be routinely done on babies, on the questionable pretext of getting a cord blood vessel pH reading. (Please see ACOG, 1995.) Attendance at Labour and Delivery Guidelines for Obstetrical Care available online at http://sogc.medical.org/sogcnet/sogc_docs/common/guide/pdfs/ps89.pdf
AAP Policy	This policy warns of iatrogenic anemic conditions through doctors' harvesting stem cells from the placenta that should have infused into the child. This unethical conduct might be considered by some to be child abuse. Pediatrics Policy on ICC available online at http://www.aap.org/policy/re9860.html
SOGC Policy #71 of December, 1998	Specified early cord clamping, (i.e., any clamping before natural expelling of the placenta without drugs, likely 30-second clamping). This deprived the child of 20 to 50% total blood volume causing anemic conditions for a duration of 2 weeks to 6 months, or more. The policy, on its merits, allowed for signed birth plans with warm water births, and gravity birth positions. However, the policy maintains the routine use of semi-sitting birth positions that are as harmful as flat on-the-back positions. Available online at http://sogc.medical.org/SOGCnet/sogc_docs/common/guide/pdfs/healthybegeng.pdf
Canada's Tri-Council Policy Statement, Ethical Conduct for Research Involving Humans, August 1998, Medical Research Council of Canada (MRC); Natural Sciences and Engineering Research Council of Canada (NSERC); Social Sciences and Humanities Research Council of Canada (SSHRC)	To quote the Tri-Council Policy Statement: C. Previously Collected Tissue, Article 10.3, page 10.4 (a) When identification is possible, researchers shall seek to obtain free and informed consent from individuals, or from their authorized third parties, for the use of their previously collected tissue. The provisions of article 10.2 also apply here. (b) When collected tissue has been provided by persons who are not individually identifiable (anonymous and anonymized tissue), and when there are no potential harms to them, there is no need to seek donor's permission to use their tissue for research purposes, unless applicable law so requires." MRC website available online at http://www.hcsc.gc.ca/hppb/hiv_aids/international/english/activity46.html NSERC website available online at http://www.nserc.ca; SSHRC website available online at http://www.sshrc.ca Research involving humans available online at http://www.nserc.ca/programs/ethics/english/policy.htm
World Health Organization (WHO), Care of the Umbilical Cord: A Review of the Evidence 1998, WHO/RHTMSM/98.4, Ch. 3	"Early cord clamping conflicts with traditional beliefs and is an ***intervention that needs justification***." Emphasis added] Having said that, WHO stated that if oxytocic drugs are used, immediate umbilical cord clamping is mandatory. They did not direct informed consent for (1) primal births, (2) the right to refuse all drugs, (3) the right not to have any cosmetic removal of the cord or cord clamping, and (4) the right to a signed birth contract. These erroneous policies began to be known as "Active Management." Anyone following such policies must be certified. Available online at http://www.who.int/reproductivehealth/publications/MSM_98_4/MSM_98_4_abstract.en.htm References to a cut cord and over 500,000 babies die of blood infection (including Tetanus) annually: Available online at http://www.who.int/reproductive-health/publications/MSM_98_4/MSM_98_4chapter1.html
ACOG Medical Bulletin #216 of November, 1995	Both the Canadian and US medical experts (erroneously) directed routine immediate cord clamping of all babies to obtain a pH cord blood sample. This dangerously cut off the flow of the child's oxygen blood circulation. A disclaimer was given on the back page of the bulletin indicating "immediate umbilical cord clamping" was not intended as a Standard of Care. Note: Bulletin was cancelled in print, Jan. 2002, but not in deed, apparently. Many previously trained medical persons (including ambulance medics) clamp off a functioning and pulsating cord or leave the child exposed to chills (hypothermia) while on the cord, causing early cessation of circulation, as though clamped. Both Dr. George M. Morley and I wrote to ACOG, however, neither of us were advised of the bulletin's cancellation. Available online at http://www.obgyn.net/english/ob/cord_blood_gases.htm

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Table 3. Case-Law

Case	Description	Reference
Ruling Case-Law, London, UK	Forced caesarean section ruled unjust.	BMJ 1997;314:993 Available online at http://bmj.com/cgi/content/full/314/7086/993
Ruling Case-Law, Ireland	Battery. Right to refuse PKU test	BMJ 2001;323:1149 Available online at http://www.bmj.com/cgi/content/abridged/323/7322/1149
Ruling Case-Law, California	Medical Battery California. According to the California Supreme Court's 1993 decision, without consent, any medical treatment is a battery. "The common law has long recognized this principle: A physician who performs any medical procedure without the patient's consent commits a battery irrespective of the skill or care used.	Daniel Thor v. The Superior Court of Solano County 93 C.D.O.S. 5658 at 5659
Ruling Case-Law (Chow)	Child was deprived up to 50% total blood volume after immediate cord clamping. Comments: It is logical, to put a finger and/or a sponge between the neck and the cord, to reduce risk of neck injury, rather than put on two clamps and cut the cord denying infusing of oxygenated blood into the child's expanding lungs. Had this method been used, rather then a directive—a cord around the neck, cut the cord—the child would have been nearly normal. The mother was not truly informed, this being her first birth.	O.J. No. 279 DRS 99-03087; Court File No. 92-CQ-017535, Ontario Court of Justice (General Division) Available online at http://www.sommersanddroth.com/case-law-chow.htm
Ruling Case-Law (ING)	This child suffered blindness and was paralyzed in a manner similar to that of the male Chow infant as a result of his circulation being cut off by mid-forceps. The mother was apparently drugged and could not push out her baby normally.	Available online at http://www.sommersanddroth.com/case-law-ing.htm
Crawford v. Penny (Duty of informed risks)	In this case, the mother was over 40, diabetic, and was having a large child. She had no informed consent that the child would best be delivered in a larger hospital with C-section services immediately available in the case of shoulder dystocia. The mother's pubic bone was broken as was the child's clavicle. The child is now 21-years-old and has severe CP. She was recently awarded a $10 million settlement for birth injuries believed preventable. (Over $40 million in damages have been awarded to children, born by methods of active management. There are more to come for law suits of flesh eating diseases for C-section births. Yet, the mothers are not educated to be in charge and have primal births, in their homes or in the hospitals.)	Court File No. 2465/94; Ontario Superior Court of Justice; Power J.; January 15, 2003 Available online at http://www.lotusbirth.com/doc/FEB2003Lotusbirth-955.htm
Class Action. The Edmonton Sun	100 families launch massive lawsuit over drugs they say made children sick. $1 billion asked, plus $250 million in punitive damages. Thimerosal, an ethyl-mercury derivative, used to preserve the vaccines, resulted in onset of autism following vaccinations.	
John Moore v. Regents of the University of California	Who owns your genetic information, April 3, 2001. Surpassing the material: The human rights implications of informed consent in bioprospecting cells derived from indigenous people	Available online at http://www.richmond.edu/ http://forhealthfreedom.org/Publications/Informed/WhoOwns.html http://law.wustle.edu/wulq/78-3/wu.pdf
Yurko, Alan R., Orlando, Florida	Personal letter alleges 5-week premature birth, use of pitocin, immediate cord clamping, multiple vaccinations; then, injections of six (6) separate vaccinations at 2-months-old.	Yurko website: www.freeyurko.bizland.com Toxicologists report available: Al-Bayati MA. Medical Veritas, 2005;1(2):201-231;232-238 (www.MedicalVeritas.com)

Bibliography

[1] Chow (Litigation guardian of) v. Wellesley Hospital. O.J. No. 279 DRS 99-03087 Court File No. 92-CQ-017535, Ontario Court of Justice (General Division), Toronto, Ontario, Lissaman J.. Available online at http://www.som mersandroth.com/case-law-chow.htm Accessed on 03/18/2005.
"In general an acute loss of 20% of the blood volume is sufficient to produce signs of shock and will be reflected in a fall in hemoglobin levels within 3 hours of the event." Shock of blood deprivation in neonates can lead to their deaths.

[2] Reproduction. The Cycle of Life. K. Jensen. U.S. News Books, ISBN 0-89193-606-8 and 0-89193-666-1 (school ed.), 1983: 98.
"After the placenta is delivered, the doctor will examine it to make sure it is intact. It is then discarded or sold to companies for use in research or beauty products." Logically, if the placenta is full of stem cell blood, it is likely that the placenta is drained at the hospital's labs; then blood from the placenta is sent to stem cell blood banks.

The baby has been wrongfully deprived of up to 50% of its total blood volume—full of nutrients, enzymes, hormones, proteins, and likely the iron reserves—causing the baby to be anemic.

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[3] The Neonatal Resuscitation Policy Guidelines. The Department of Anaesthesia, Ottawa. The NRP guidelines, Elliot RD. Available online at http://www.lotusbirth.com/doc/FEB2003 Lotusbirth-193.htm
"...revealed that 1 in 16 babies are now requiring to be revived."

[4] Manual of Nursing Practice, 3rd ed., J. B. Lippincott Company, Philadelphia & Toronto, 1978-1982.
Report gives visual facts of science: observable, if the placenta is drained after immediate cord clamping, that in circulation of the fetus changes to that of an adult, "Placental transfusion at birth--increases in blood volume of 60% if cord is clamped and cut 'after' pulsation ceases."

[5] The Merck Manual, Health Management in Normal Neonates, Infants and Children, Initial Care, 15th ed., Merck & Co., Inc., Rahway, New Jersey. ISBN 0911910-06-9 and ISSN 0076-6526, 1987:1804.
"The umbilical cord is clamped and cut after the first breath..." Where is informed consent and a signed Birth Contract to (a) protect the baby from oxygen debt and (b) maintain blood volume and pressure to the brain, lungs, heart, and other organs?

[6] Gabbe: Obstetrics: Normal and Problem Pregnancies, 3rd ed., Churchill Livingston, Inc., 1996.
This reference, often quoted by the College of Physicians and Surgeons resource material, indicates that the timing of the of the cord clamping is determined solely at the doctor's discretion. It incorrectly states, "In most instances, the volume of this transfusion is not important, and the timing of the cord clamping is dictated by convenience."

[7] Nilsson L. A child is born, ISBN 0-440-50691-3, 1993.
Photographs in this book depict nurses rushing a child down the hall for revival by special machinery after the umbilical cord was immediately cut following delivery. It erroneously states, "The umbilical cord is cut immediately after birth, although the placenta remains in the uterus." Due to this erroneously specified procedure, it follows that "Sometimes, when a delivery is protracted and arduous for both mother and baby, the newborn baby must immediately be given extra oxygen. Soon its heart will beat normally."

[8] Martindale. The Extra Pharmacopoea, 31st ed. Evaluated information on the world's drugs and medicines. The Royal Pharmaceutical Society, London. ISBN 0-852369-342-0, 1996:1123.
With regard to preservatives used in oxytocic drugs, this book states, "Acute poisoning with chlorbutol (chlorobutanol) may produce central nervous system depression with weakness, loss of consciousness, and depressed respiration."

[9] Pearce JC. Magical Child. Chapter 6: Time Bomb. Clarke, Irwin & Company, Ltd. Toronto and Vancouver, Canada, 1977:41–50.
Author writes, "In America, birth has become a technological, profit-making event. Pregnancy is quite literally treated as a disease, with technological-surgical delivery the final remedy of that disease... since the time of Louis XIV, forced victims to take the supine position—laid out flat on the back and, in a shocking number of cases, even strapped down, a position that would strike terror into the staunchest soul." The author continues, "What does the word supine mean? Helpless and incompetent.

This position throws every muscle and bone of the body completely out of line for natural delivery of an infant from the womb and makes the delivery extremely difficult. The author summarizes the conclusion of William F. Windle who wrote, "Our experiments have taught us that birth asphyxia lasting long enough to make resuscitation necessary, always damages the brain... Perhaps it is time to reexamine current practices of childbirth with a view to avoiding conditions that give rise to asphyxia."

[10] Canadian Medical Association Journal 1992. Reference No. FN92-03, Revision in Progress March 23002. Guidelines for transfusion of erythrocytes to neonates and premature infants;147(12):1781–6.
From 10 to 15% of the blood volume in seriously ill neonates is often removed for laboratory tests over two to three days. The transfusion of blood products to neonates (infants up to 28 days of age) is common. Older infants, especially those with problems after premature birth, may also require transfusions. Most frequently, erythrocytes are transfused to restore circulating blood volume and to increase oxygen-carrying capacity or to replace blood removed for laboratory tests.

[11] Peltonen T. Placental transfusion: advantage and disadvantage. Eur J Pediatrics, 1981 Oct;137(2):141–6.
This author references a 1959 file that demonstrated shrinking of the heart. He states, "In the Scandinavian Congress of Physiologists in 1959 we showed a film of the first breath. If the umbilical cord is tied prior to the first breath, the result is decrease in the size of the heart during the first three or four cardiac cycles. Then the heart again increases in size, *almost* to that of the fetal heart. On the basis of these observations, it would seem that the closing of the umbilical circulation before the aeration of the lungs has taken place is a highly unphysiological measure which should thus be avoided. Although the normal infant survives without harm, under certain unfavorable conditions the consequences may be fatal."

[12] Tsiaras A. From conception to birth: a life unfolds. Doubleday, a division of Random House Inc., Available online at http://www.riccomares ca.com/Artists/Contemporary/Tsiaras/AlexanderTsiaras.htm
(Last accessed, March 22, 2005)
Author displays animated pictures of the action of the pelvic bones opening during the birthing process.

[13] Hematology of Infancy and Childhood, 3rd ed., Nathan D., Oski F., eds., Philadelphia: W.B. Saunders Co., 1987:30
Dr.Oski states, "In general an acute loss of 20 percent of the blood volume is sufficient to produce signs of shock and will be reflected in a fall in hemoglobin levels within three hours of the event." See ref. [1].

[14] Anesthesia. Miller R.D., ed., Anesthesia, 2nd ed., New York: Churchill Livingstone, 1986.
"... early cord clamping could result in a depressed neonate." See ref. [1].

[15] Diagram of Fetus Circulation to Neonate/Adult Circulation. Available online at http://www.lotusbirth.com/doc/FEB2003Lotusbirth-435.htm

[16] The Province, Sunday, September 29, 2002. Super bug threatens babies at Children's Hospital, page A3.
Evidence in Canada of infections that could get into a cut cord or any prick in the baby's skin. "An outbreak of methicillin-resistant staphylococcus aureus (MRSA) at B.C. Children's Hospitial in 1998 killed two babies and infected 47."

[17] http://www.babycenter.com/topic/5732.html
Proof of cut cords getting infected—generally in hospitals.

[18] www.lotusbirth.com/_cont260.htm
Table of Contents of Lotusbirth: To find subjects, please use the *Edit* and *Find* topic for the page. Suggested topics include: Birth Contract, The Canadian Criminal Codes, When the Fetus becomes a Human Being, Common Nuisance, Endangering a Minor, and other violations to the person, holes in the heart, increase of disease in children, autism, etc. Specific suggested reports include: Mavis Gunther and T. Peltonen.

[19] Caroline, Nancy, M.D.: Emergency Medical Treatment, 3rd ed., Pittsburgh University, Boston, Publisher, Little Brown & Company, ISBN 0-316-12-886-4, page 519. (Directs ECC and ICC of the umbilical cord).
In British Columbia, Canada, the BC Justice Institute which trains medics and has the contract of emergency care and selection of textbooks and training, does not permit instructors to tell the medics of informed choice of no clamping off the cord, ever. All levels of the Provincial BC government failed to investigate the information medics used and determine whether or not it was dangerous. The instructions were: clamp the pulsating cord, tend to any concerns of the mother, then cut the cord; if the placenta was birthed, it is put it in a sterilized environmental bag and taken to the hospital. No one ever learns how much blood the child was deprived—similar to what is done also in maternity wards. It is kept confidential as to where or how the blood, the cord, membrane, or placenta is "disposed".

[20] Globe and Mail, Canadian newspaper article by Anne McIlroy and Paul Taylor, March 23, 2001.
Study indicated that 60% of the medical students witnessed a doctor acting unethically; 47% of 103 students interviewed reported they felt pressure to act unethically very frequently, frequently or occasionally. Students felt they were providing substandard care, which included being part of a team that secretly administered intravenous drugs to a woman who had requested a narcotic-free vaginal delivery.

[21] Active Versus expectant management in the third stage of labour (Cochrane Review), Prendiville WJ, Elbourne D. McDonald S, The Cochrane Library, Issue 2, 2004, Chichester, UK: John Willey & Sons, Ltd.
Three of the five clinical studies used as a basis for this report did not consider the child outcomes (Apgar Tests). This report actually compared active management of two drugs with active management of one drug; in other words, "Expectant Management" was not really part of the study and therefore the conclusion that "Active Management is superior" is erroneous.

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