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

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.

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

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.

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

- 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-

	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

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.

[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.