

THE MIDWIFE AND NURSE'S GUIDE  
TO USING PHYSIOLOGY TO AVOID ANOTHER  
UNNECESSARY CESAREAN

# *Changing Birth ON Earth*™



GAIL TULLY

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The Midwife and Nurses Guide to Using Physiology to Avoid  
Another Unnecessary Cesarean

Gail Tully

## The First Two Chapters

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## **Changing Birth on Earth**

### **A Midwife and nurse's guide to using physiology to avoid another unnecessary cesarean**

Gail N. Tully

1959-

Electronic book

978-0-9776793-7-9

1. Pregnancy–human
2. Labor–childbirth
3. Natural birth–handbook

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Cover photo by Jackeline Goulart Tonissoli of Jackie Goulart Fotografia. Inside photos: pregnant woman crying in joy by Candace Barber; jiggle on the couch by Meredith Westin Photography; a side-lying release and hands jiggling the thighs by Chris McBride; the two side-by-side side-lying release pictures and Gail's head shot by Kristin Tangen; six photos of the two moms in the hospital birthing room by Megan Crown; the squatting couple by Tanya Villano; and an unknown photographer (at Nikki Zerfas' workshop) of the Flying Cowgirl position on a hospital bed. The rest of the photographs and all the illustrations are by Gail Tully. Images used by permission. In the event that any acknowledgment has been inadvertently omitted, all necessary corrections will be made in future printings.

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Please visit our website for more images of the techniques in Chapter 4 and the birth positions in Chapter 6. After reading this book, attend our free one-hour course for more understanding of The B. I. R. T. H.:

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Published by Maternity House Publishing, Inc.

10545 Humboldt Avenue South

Bloomington, Minnesota 55431-3118 USA

[www.spinningbabies.com](http://www.spinningbabies.com)

<https://www.facebook.com/pages/Spinning-Babies/140458025970181?fref=ts>

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*Writing this book has been a meditation on the gifts Carol Phillips has offered our world.  
I dedicate this book to you, Carol, with a choir joining me, in deepest gratitude and awe.*

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# **Chapter 1: Cancel the OR: The Surprising Paradox of Easing Birth**

## **My Ideal Reader's Story**

You and I are about to take a bird's-eye look into a birth emergency. Let's explore from our all-seeing vantage point how the night is going for nurse Tori and her dedicated colleagues at Tippa-Cal Hospital. Perhaps you are a midwife or intrapartum nurse and have had a night like Tori's in which you, too, were strongly aware of the two parallel realities happening in childbirth even as you exerted your expertise to save a life.

Tori's hand gripped the side rail, alternately pulling the gurney down the hall and pushing it away from hitting the wall as she ran. Alvita ran up and grabbed the other railing on the rolling bed, and she ran with them. The charge nurse ran in front of the gurney. The doctor was already scrubbing, even though the anesthesiologist had just parked his car. Emmett, the person trying to birth a baby, was not forgotten by Tori. Emmett's hand clutched Tori's wrist at the railing. This wasn't an easy ride for Emmett. Tori noticed how smooth the bed rolled at this speed compared to the old beds. The IV pole didn't rattle. Her thought pattern was disconnecting, Tori noticed. She made herself feel her own body running, breathing. The rescue had to be fast.

Emmett's identity was charted as a "29-yr-old, P2 G1 at 39 weeks' gestation" and her chances of surviving emergency surgery were far greater than a hundred years ago. But Tori knew Emmet wasn't safe yet. Each beat of her heart slammed her determination deeper, "This child would have a mother and this mother would have this child!" Tori could feel pride in her team. The timing of her nursing career allowed her to see the benefits of penicillin, blood replacement, and women who had grown up with access to fresh milk and vegetables in childhood – the stuff to grow healthy pelvises. Even iodized salt contributes to preventing thyroid deficiencies. But Tori wasn't thinking of the advancements she was taught in nursing school.

Time was of the essence. Tori looked down to notice the spreading, red-tinged puddle between Emmett's legs in her peripheral vision. She turned her head over her shoulder and noted Emmett's frightened eyes were still tracking. She was breathing hard; her breaths were quick but not shallow. Let's hope the anesthetist had begun before the doctor had her scalpel ready. This was

going to be a close call. It was too bad that a routine procedure that was supposed to help start labor caused this problem.

The labor hadn't been picking up. Walking the halls and even dancing with the music on, the labor was not progressing, but Emmett's contractions were persistent and keeping the patient from getting any rest, Tori lamented. Tori loved helping the person struggling with labor have a positive attitude and find positions that helped. Birth was amazing, and she loved reframing the new parents' fears into acceptance and even determination. But the baby was big, the doctor said. The mother was definitely uncomfortable and frustrated. So, it seemed reasonable for the doctor to suggest an everyday intervention: stripping the membranes to try to start labor. Beginning like a vaginal exam, the finger keeps pushing upward into the cervical opening and then twisting inside, this way and that, to separate the edge of the sac from the lining of the uterus. An achy night of increased hormones starts a real labor about 10 percent of the time.

The doctor and patient talked about it, and the mother agreed. She was already 1 cm dilated, so it would be easy for the doctor to do it. Emmett wanted to avoid an IV drip and have a natural birth. The doctor thought it better to have the baby before the baby was much bigger. The doctor said "stripping the membranes" would work "if nature was willing." Tori lamented the paradox as they slowed to stop in front of the OR doors. This time, however, the amniotic sac broke. And in Emmett's case, the cord washed down with the amniotic water. Worse, this was not a normal cord with a normal insertion to the placenta. The bright red tinge in the water and the sudden drop of the baby's heart rate made the doctor speculate that a delicate velamentous cord attachment, with lacy, exposed veins, had been torn by the sudden drop of the cord away from the placenta by the rush of fluid and the decompression of the uterine wall. It was also possible that the blood was not from the cord but that the placenta had separated from the uterus when the uterus shrunk a bit from the release of water inside it. Neither complication was expected. Rather than wait for an ultrasound, the team flew into action. Minutes would matter.

Alvita waved her badge over a sensor and the door to the surgical suite opened.

The bright lights sharpened the echoed sounds of the surgical staff in the OR.

Tori sighed. Whatever nature had intended for this birth was behind them. She leaned into the gurney and shoved the bed forward again. She focused her attention on the next action now that birth team assembled in the operating room. The edge of red-tinged water had reached the edge of the mattress. The baby was going to need blood replacement, no escaping that. Tori's teeth

pressed into her lips sucked in between them. If the baby were still alive. *They need you now*, Tori removed the thoughts from her head. *Don't reflect. Act. You've got to be fast. Keep it clear so you can help keep them alive.*

The OR was a whirlwind of activity. The doctor walked through the door from scrubbing, hands held high and dripping, and the scrub tech helped dry his hands and don the sterile gloves and gown. Alvita and Tori quickly slid Emmett from the bed onto the narrow rectangular operating table.

Tori moved quickly taking a few precious seconds to look Emmett in the eyes and say, "I know this is all moving fast, but we're here for you and we're here for your baby." Her words were more than comfort; they oriented Emmett to the purpose of the flurry.

The charge nurse pressed the Doppler into Emmett's abdomen to find heart tones. "We're in the 70s," she called out. Emmett didn't have an epidural placed, so she'd have to get a general anesthetic and be unconscious for the birth. The anesthesiologist was ready. The doctor was ready. Tori called out the patient name and reason for the surgery, as Emmett's belly was quickly prepped and the rescue began.

An hour after the successful surgery, Tori was back at the labor nurse's station. She and Alvita got a verbal report from the Recovery Room nurse. The mother was doing fine and baby was under observation in the nursery. Though Tori's job duties returned her quickly to Labor and Delivery, she followed her patients after their surgical births, even when events weren't so dramatic. An umbilical line was giving the fluid replacement to the baby, but all reflexes were normal. The sense of relief swirled and wobbled like a dying tornado. Tori's pride in her team was strong, but inside she sensed an anger mounting at the unending cycle of interventions that seemed excessive. This was a young, healthy woman. Why wouldn't her labor start smoothly? Were they just too eager to start labor? And was anything besides intervening, or waiting, even possible?

Tori charted, and she wondered about things that are never written in a chart. There was the data she reported, and then there was the birth itself. Thirty-nine weeks, elective induction for size of baby. This baby could have stayed snug for two more weeks. Would the pound the baby gained in those next two weeks condemn the baby to shoulder dystocia? Could the cord have been safely protected by the pillow of amniotic fluid had the membranes been left intact? Hadn't it been until the waters were manually broken? Why did the tolerance for allowing normal pregnancy and birth to unfold get shorter every year?



Tori saw Alvita at the nurse's desk doing her own paperwork. "I just wonder what would happen if more healthy women could just go into labor on their own," she mused out loud.

"Everyone here gets frustrated, wants to control the body, but no one asks the body what the body needs to do!" Alvita had a lively way of commenting. She had years of experience at Island Community Hospital before she came to California.

Tori and Alvita let their own heart rates normalize with the rhythm of their charting.

Izzy heard them talking as she emerged from Labor Room 4 and said with a sweep of her arm, "Maybe they just have to accept that having a baby is gonna hurt, and they just have to do it."

Another nurse sitting nearby leaned in Izzy's direction and raised her brows. "She thinks *this* is bad. Just wait." Tori wondered at the harshness of the prognosis. Especially since that nurse's patient came in already pushing. Izzy and the other nurse both had about as much experience as Tori did herself. But the view of labor seemed to be, well, just that, labor. The miracle of birth just wasn't as evident in their words. Tori knew Izzy loved her job, loved being competent, but sometimes Tori wondered if Izzy connected what she did to the person she was doing it for.

Izzy's patient had been there since the night before, and the day before that. In fact, she had come in during the middle of the night before last. Izzy had actually gone home twice to sleep while her patient had labored on with a day nurse. They increased the rate that the Pitocin dripped into the IV, the artificial hormone increased uterine contractions incrementally and kept the contractions coming. An epidural anesthetic was pumped into the space between two layers of membranes protecting the spine. And, if everything went to order, they would soon break the bag of water.

"Consider the question," poses Alvita with a thoughtful tilt of her head. "Two women, two holes, just about the same size, and two babies just about the same size. Why don't those babies come out with the same amount of time and effort? Why is labor hard for one and not for the other?"

Tori set her hands in her lap. She had a feeling they were about to hear a pearl of wisdom from the older Alvita.

"You gotta show the women they don't have to wait and worry. Help 'em find that oxytocin. Nature doesn't follow a calendar. You think the day you're born is as blank as any other? Life has meaning. That beautiful oxytocin comes flowing through our veins to help us handle the

pain. We gotta trust what's provided." Izzy's lip curled a little to one side, but Alvita had Tori's attention. "Neither the world nor the clock has any help for birth hormones. Pushing nature into a schedule and calling every variation a risk just has everyone in a sweat."

Izzy said, "Hello! There's plenty of research on what makes risk real!"

"There is plenty of research on Pitocin, and it's not all good. And there's nothing holy about the studies on inducing for size." Alvita settled back into her story. "We try to jump-start the body with fake oxytocin. Pitocin replaces the body's natural oxytocin. Without the brain receiving that natural 'love hormone,' the contractions come on – but so does the pain, and a fight-and-flight cocktail is dumped into the blood and onto the brain. The brain freaks out, and shuts down the uterus. It wants to protect the baby. But it's preventing progress so the labor doesn't come on good.

"Pitocin gets contractions going often enough, but not always. Pitocin doesn't get the mother high on hormones. They call it 'Pit.' Maybe for those pit bull contractions it causes. The mother doesn't like it. And the baby doesn't like it. And when the baby doesn't like it, I don't like it!" The three listening nurses weren't about to argue. They had heard all of this before, but Tori felt the wisdom rather than the rant this time. She heard a message between the words.

"You gotta get loving and breathing and do all that massage in the dark. Let them know that the start of birth isn't something to control. Let them know their bodies have the key. That'll get that oxytocin flowing. The mind gets sleepy, that's the way. Then the body can get to work. Then the baby will come."

Izzy rolled her eyes and laughed, "Sure, I'll just go tell 'em it's time for love making. It's pronounced, 'ep-uh-dur-al!'"

Tori bit her tongue. She was frustrated with that attitude, but it wasn't Izzy's fault. Izzy had found a way to cope with the demands of her job, by becoming very good at applying the tools at her disposal. It didn't make it ideal, but the alternative wasn't as reliable as an epidural. Tori wasn't giving up. What Alvita was saying was indeed supported by the experts. But it wasn't easy to replace Pitocin in a hospital, as it had become a standard of care for common "problems." Alvita kept them all grounded. Without her, they would all lose perspective. Tori got a little mad that the other nurses didn't take the time to listen.

She herself often felt like something bad could happen the very moment she didn't keep watch. Today was an example. Alvita was right there helping in the emergency, but she also put

the event in context. Alvita talked about attending births in The Islands. “Just as nature would do,” Alvita said, as Tori watched Izzy walk back to the labor room. Everyone knew that in that labor room, Pit was running, the epidural was pumping. The doctor on duty tonight was unlikely to break her water, but the one on the morning shift would. Still most likely, they’d be in the operating room for the birth. Step by step, the dominoes of interventions were set in place and invariably knocked down.

Tori turned back to watch Alvita, who herself had turned back to her paperwork. A feeling flooded within her. She suddenly connected a paradox: though Alvita knew birth, this place was not a place that Alvita could use the things she knew best. Tori wondered, why couldn’t birth be like that here? Then laughed a little to herself. Whatever *that* was, she knew she wanted some of it! She didn’t really know, but she sensed the possibility that birth could be more than it was allowed to be in this hospital. Izzy would never even ask such a question.

She considered Alvita in her younger years. What had she seen? Something about Alvita’s gaze into her own past compelled Tori. She glimpsed a young Alvita on the island, and a palpable sense of connection and purpose, for women with more involvement in their own births, came with the vision.

Alvita’s earlier experience was in a hospital, too, but the births then seemed somehow to be more connected to life and accepted by the hospital staff as the body’s rightful work. There was trust in the process. Birth was still part of nature. Alvita was staring at her computer screen. But what Tori saw reflected in Alvita’s eyes was more than the analysis of a monitor reading. She had skills, and wisdom for helping families navigate normal birth. Fewer labors had been clipped short. True, the advantages of today’s technology weren’t available then. That would have been a real tragedy in some cases. Tori was grateful for technology available at Tipapa-Cal-Central. But many labors that are managed with technology and directed to interventions still would have occurred normally and most of them with good outcomes. Tori just wanted to know why.

Tori turned back to her charting. Where’s the line between what nature can provide and what we have to offer with birth technology and careful management? And when we draw that line, are we making the right call?

## **Two Views of Birth**

We'll leave the hospital scene now and give Tori some time to consider these two very human needs of flow and security.

The perspectives held by intrapartum nurses and midwives shape their work as birth keepers. A birth keeper holds the vision, the beliefs that model the possibilities about birth for parents and the public. The birth keeper transfers what they hold to be true about birth to parents through the beliefs tightening their muscles or relaxing their faces, the rhythm of the breath, and the patience and engagement with the birth process they nurture.

It's 80 years now since a British doctor, Grantly Dick-Read, wrote of his astonishment that a woman who had just given birth in her home said, "It didn't hurt. It wasn't supposed to, was it, Doctor?" His books, *Natural Childbirth* (1933) and *Childbirth without Fear* (1944), related joy and maternal love to nonintervention, values that influenced the early homebirth movement in the United States. He joined Denman and other physicians, noting the power of the mind-body connection. They observed that labor pains result from physical tension caused by fear and that learning to relax would decrease the pain enough to cope with labor. The eager obstetrician and midwife whose rush to interact was seen as the cause of labor complications. The fear, tension, and pain syndrome continues as a popular description for motivating parents in developing coping skills. Grantly's gentle, if gently patronizing, observations offered a comforting position to counter the dehumanization of the birth experience until even today. The person of the birth giver was acknowledged and the emotional importance of pregnancy and birth was recognized.

Compare Dick-Read's vision to that of US physician Dr. Joseph Bolivar DeLee, "the father of modern obstetrics." DeLee's promotion of episiotomy and routine forceps for all births began an era of obstetrics untethered to women's autonomy or dignity. Instead, DeLee speaks of gaining his own dignity as a baby doctor by taking birth with force. His competency impressed colleagues who accepted his cut and pull methods under the name "preventive obstetrics."

By 1915, DeLee shared the premise of his paradigm:

*"Obstetrics has a great pathologic dignity. Even natural deliveries damage both mothers and babies, often and much. If childbearing is destructive, it is pathogenic, and if it is pathogenic it is pathologic. If the profession would realize that parturition viewed with modern eyes is no longer a normal function, but has imposing pathologic dignity, the midwife would be impossible even of mention."*

The epigenetic distress continues today in US midwifery, regardless of faltering outcomes. After DeLee denounced midwives, he brought nurses to his view by authoring a nursing textbook to define their position in the hierarchy. In the United Kingdom, midwifery continued without the professionocide seen in the United States, and UK midwives' evidence-based care practices includes more physiological birth.

Now it gets fascinating. Dr. Grantly Dick-Read wrote the dedication to his book to Joseph DeLee saying, "For his kind interest in my work and for his personal friendliness and appreciation I shall always be sincerely grateful." Suddenly two who seem so opposite have a third perspective.

Like Tori, we are often living between the natural forces of birth and the reassurance of informed management. Someone with a birth plan comes in, and there's a cringe. They resist "preventative obstetrics," and yet that resistance itself separates them in relationship from the professionals they sought out. The assumption is the parent(s) may not be educated in the usefulness of the things they list with a big, bold "No!" They want something natural to unfold without the services designed to keep them safe until the rescue measures are proven necessary.

Labor and Delivery nurses might like a little credit for their skills. The motto of pride might be, "We have your back when Mother Nature turns her back." But if you are like me, you might notice that it isn't Mother Nature who's turned her back but we who have lost connection. And we long for it. We're curious to trust the full process of human reproduction, and yet we, too are constantly calmed by the predictability that management assumes for the hidden nature of pregnancy and birth.

Staying in the tension between flow and security keeps us in a permanent relationship with this dynamic duo. Yet there is security when nature's hormones flow and a harmony within oneself from responding, rather than reacting. The question of safety seems to take priority over physiology: How early can we induce before it's too early? What is the ideal rate to keep routine cesarean safe before the rate of placenta previa or accreta causes overwhelming stress and "unacceptable" loss or near loss of life? This last question has an unspoken clause that could be worded so we knew we were being asked to *meet economic margins* or *make efficient use of the OR*. These questions are on par with Dr. DeLee's "pathological dignity" paradigm of obstetrics. But such focus diverts thousands of providers away from "physiology first," a paradigm that begins with honoring the birthing pair. To find security in humble physiology, we have to come to terms with where we fit, and with what amount of fluidity, on the spectrum of security and flow. The

extreme of complete intervention was promoted from the first journal issue by the loudest voice in obstetrics for over 100 years.

Dr. DeLee was a champion of his team. Science, in 1920, was already more fun than physiology, but in 2020 the science of physiology offers information to enlighten the most evidence-based birth practice. I believe we now have the science to support a third perspective. Every professional wants to contribute to safety. That's security. But parturition is a function of nature. That's flow.

Flow is present when the birthing person finds their inner strength, and they, mostly they, in actuality, contribute to the success of their own birth. Flow is in the very human process of birth with all its glory and risk. But the flow of birth physiology is a security, too, for the function of the body is hard to replicate safely.

Can a birth be allowed to be natural and still keep the physical process safe? This might be the surprising paradox of childbirth. To find peace between the duality of surety and nature's mystery, we must be affirmative in the question, Is there security in nature's process? The birth process is so intimately connected with the parenting process, with breastfeeding and nurturing dependent on the body's hormones, how can intervention be sure to be safe for the development of parenting? Interrupting the building blocks that create the instincts of parenting seems to be another risk we'd do well to avoid.

A belief coming from obstetrics is that a managed birth is a safe birth. The challenge is finding improvement by managing nature's own processes. Where's the happy medium between hormonal health and overseeing the moments where an individual needs help? And how do we help without disempowering? We don't want to strip the power from the parent, and at the same time, we have a lot to offer when things do go wrong. There's value in meeting the needs of both the parent and professional to contribute to a safe and satisfying birth. And though the strategies of freely birthing or managing labor seem to be opposites, both are strategies vital to the goal of a healthy baby and a healthy mother. The dignity is found in the balance. It's rather a compromise to forcibly cut through the imbalance. It may save a life, it may cost a life; but it's admission we lost contact with human physiology, through sickness, injury, or our own lack of foresight and preventative care.

Relationships between bodies in birth and the managers of care are complex with questions and decisions about what should be done. The mother can be forgotten as the expert to her own

experience. The natural process has gotten us through millennia and the obstetric model has saved thousands of lives. It's an "and" not an "or." The complexity is that both have benefits and both have shortcomings. Sometimes that paradox can leave us stuck in the middle. How shall we then see birth?

## **Know Your Own Paradox**

The good news is we don't have to give up security to get flow. We can't actually. They aren't opposites but allies. One contracts while the other expands, but they ebb and flow together. What we can do is simply recognize that we may be more comfortable with one. For well-being, we can learn how to honor our relationship so we can move with grace between the two allies.

Inside all of us are conflicting beliefs. Beliefs are trained into us and we apply them to situations for which the story fits. Women are wise, but patients are naive. Evolution chooses the fit but the size of the human pelvis didn't keep up with the size of the human brain (if that were true wouldn't it undo evolutionary theory?). We value a care plan, but the patient with a birth plan is heading for a cesarean. The human brain can hold thousands of conflicting beliefs without noticing the stories conflict, until the time comes when at least one of the conflicting stories brings you to question the premise that has now become a restraint. Perhaps one of these polarities brought you to this book? One something like:

- We can trust our bodies versus We tried everything but nothing worked.
- Birth is a natural function versus Be ready for anything.
- It doesn't matter how we get there as long as baby is healthy versus "She got her birth!" when the vaginal birth after cesarean (VBAC) mother pushes her baby out in glorious accomplishment.
- Don't apologize for making noise/wanting an epidural versus She thinks this is hard! Wait till 8 cm!
- Babies don't know (don't remember) versus This baby is so stubborn!

Do you see how some polarities can be harsh and some kind? We tend to polarize that way. Notice how beliefs are repeated down the generations of providers, just like generations of families. Often our stories seek to keep the status quo. We then navigate the effects of stagnant beliefs on our own physiology.

The richness of life gives us more than a set of rules. We also need the art of innovation. Freedom means we have to let go, for just a moment, of the reliability of control. Trust grows by taking the journey into vulnerability to find out that our self remains whole anyway. These are the ingredients of intimacy in a personal relationship. And the same ingredients to trust birth. We are ever engaging in the tensile pull between the unknowns of an individual with the perceived known of management, even at the cost of intervention.

Where is your comfort in the seeming opposites of trusting birth and relying on technology?

On one end of the spectrum is birth as nature provides. We can rename natural birth and call it physiological birth: the baby is born by the power of the body, with support, but without medical assistance. At the other end of the spectrum is technological birth. Intervention by intervention down the line, one-third of the time, to the cesarean. These are opposites.

Yet at any point along this line we can support any number of body functions to be as physiological as they can be with necessary technology. Even with a cesarean the cord can pulsate to closure and skin-to-skin contact may replace the baby's exam table. Each time we protect physiology, we act to protect the developmental phase of parenting being developed by those hormones.

There's no need to defend the cesarean. All we need is a loved one whose life is saved by a cesarean, and we won't forget it. There's no help in attacking the person who conducts cesareans or the person who has one. That's just mean. Rather, let's invite the activists who look at the rate of cesarean and the economics that push that rate up. To protect the future of birth we must identify that sweet spot between what saves lives without a debilitating effect on the birth in need, wellness in the present and in the future, and future pregnancies and births.

I can't expect the cesarean rate to come down to humane levels unless I replace the reasons for those cesareans with a system of very practical solutions. An over use of technology serves to reduce the fear, suffering, injury, and death currently managed by those surgeries instead of physiological measures. The fear and frustration of labor dystocia, shoulder dystocia, and breech vaginal birth are all safely supported through skills for flexion and rotation of the baby. These, too, are lifesaving maneuvers. A profoundly better understanding of anatomy results from using the techniques in this book to overcome labor dystocia. (I discuss breech and shoulder dystocia in our online courses.)



Some would say there is no shame in an epidural, and of course, that is correct. The shame is that the epidural is the main expression of compassion in maternity care. The mercy expressed is the epidural itself and not human touch. But no one wants suffering, and if the comfort measures of the doula, nurse, or midwife or the techniques detailed later in this book aren't soothing (while shortening) labor, then, deep-water immersion, gas, or, certainly, the epidural can be valuable tools for many births.

This isn't a book about birth under the stars (although I think that sounds lovely). No, I'm here with you in the hospital or birth center. The people you are serving have chosen to give birth there either enthusiastically or because they don't have a satisfying alternative. The midwife in the homes around the world depends on physiology. Every tip can make a difference where there isn't a surgical team ready. Collaboration saves lives. While there may seem to be two opposites, knowledge of one another helps us find balance and inspires best practices.

The words we choose to say reflect the internal chemical reaction inside us as if feelings of safety or unsafety are linked to reasons. A sense of safety is linked to physiology. When we're in the flow, we feel confident. We have tolerance, flexibility, curiosity. When we need reassurance and need it fast, everything can feel risky. In our search for certainty, we can resent spontaneity, that is, nature's timeline, someone's requests in their birth plan, and any other unpredictable and undefined needs coming at us. The words and stories that come to mind are those that defend our feelings. Other stories and memories don't come to mind, even if they also happened. Our synapses didn't elicit those responses. Change our physiology and the story of birth improves.

Quality of life after birth is enhanced by birth physiology. Positive brain changes emerge from the hormones that let birth flow. Unconscious information and assumptions that the baby is sick or faulty decrease when human birth has physiological support like privacy, dim lighting, low stimulation, and continuous peer support. Protective and nurturing behaviors increase. The quest for easier physiological birth is to for this body response.

I ask you to notice your comfort and discomfort in your body when we talk about birth. As we have compassion for the fears that come up our stress reduces and kindness to ourselves and others allow love into our lives and work. To do birth work is to be guardians of the moment that mother and baby meet. So to allow our love to embody our work is to literally surround this magical meeting with an atmosphere full of love molecules.

To remove the obstacles of love, we begin to acknowledge where adrenaline blocks our oxytocin. Running in the fast lane means we're not cruising in the slow lane. Oxytocin makes us sleepy. In labor, feeling sleepy is a bit distressing for the birthing person who is used to control and a fast pace. For a provider, adrenaline is an important asset for getting our work done and dealing with exposure to grief and disappointment that comes with the job. Artificial oxytocin can make the womb contract without entering the brain blood barrier. We don't get high or sleepy from it. We don't get pain relief. Pitocin doesn't feel like love. The chemical preparation for parenting then is not love. So how do we get past the chemical barriers of modern birth?

For me, awareness is a uniting factor. The tensile strength pulling on two realities keeps us locked in a bad romance. They are binary points: Passivity on one side and force on the other.

Our journey is to disengage from the debate to wait or cut. Such dualism keeps us stuck. We are going to explore a third element by bringing the dynamic of two into three.

## **When Two Become Three**

I'm about to offer a third perspective. The two poles of "leave it to nature" and "managed at every moment," or "Nature" and "Technology," keep us bouncing like a ping-pong ball. I want to introduce a third point that is not on a line but a triangle: physiology.

Adding physiology as a third point of reference begins a supportive web for the body of birth. Now the charge can leave the dualist comparison and create a triune dynamic with birth anatomy. If you hope to free yourself and your profession from an overwhelming dependence on technology but find going all natural all the time is also unsafe, then the third point becomes essential.

Think of the baby that is staying high in the pelvis. The cervix may be fully dilated but pushing is not bringing descent. And now imagine no electricity and no way for a cesarean (though cesareans are not strictly dependent on electricity and innovations could be developed for power outages.) Suddenly you cannot be satisfied with prognosis for surgery like "the baby is too big" or "the pelvis is too small." You need a third option. If you long to trust birth, for things you can do to sooth labor pain or help labor progress even when colleagues are spent, this third approach will empower your birth care. You gain a security by the ability to read the signals and signs of birth anatomy and being able to do something for it. You found your third option.

Physiological skills in fetal rotation or resolving labor dystocia are not taught in nursing school. Because the details of fetal position and rotation are little understood they have been deemed no more important than how to code the indication for a cesarean. Watching the cervix to tell the time of birth is like watching someone's mouth to know when dinner will be served. Pressing into the spine of someone with back labor through an entire shift is not practical. The peanut ball has become the answer. But how does one position it? If a technique doesn't show a difference in 3 to 10 contractions it's not appropriate for the situation.

But avoiding surgery is not the only benefit of learning the birth process anew. Nurses tell me they see better work relationships with themselves and doctors, better mother-baby connections, and better satisfaction for everyone. Parent confidence in their own bodies and their parenting with their babies increases. Birth is more comfortable and has fewer complications. This is not a dream but something nurses, midwives, doulas, and now more doctors are seeing from beginning these physiological techniques and smarter birth positions. I believe that Spinning Babies® can help you experience your practice in such an empowering way that your setting might even become a dream birth setting.

Nurses at a high level of integration with Spinning Babies® are able to assist labors to progress without Pitocin and report fewer decelerations of the heart rate and crash cesareans. Babies gazing into their mother's eyes will be the norm. Social connections are dependent on intact vagal nerve function, which is supported by skin-to-skin contact. Mother-baby time together will be more possible with easier birth than following the trauma of a forced labor with medications that block the body's parenting hormones. Yet a glow in your workflow depends on learning the clues that identify the difference between the baby that can't fit and the baby that is simply waiting for us to notice. In just a few chapters, your eyes will see birth as never before.

A nurse shared her own story of how Spinning Babies® offered an opportunity for her second birth. "With my first kiddo, 44 hours of labor, pushed for hours and went to C-section. Because of you, I had a successful VBAC [vaginal birth after cesarean]. I pushed for eight minutes." She said she felt the key was preparing with the exercises that bring range of motion and the techniques to restore balance to the body. The way is made smooth, so to speak. "I feel like my C-section rate is lower, for sure. For the last six years."

A midwife in a remote Alaskan birth center told me she hasn't needed to transfer a mother for higher-level care in well over a year. Typically, 20 percent of birth center families may move

to the hospital for induction, augmentation, an epidural, or a cesarean. Susan Baker, a nurse that you'll meet in a minute since she hasn't been to an unplanned cesarean since she began using Spinning Babies with all her patients. This hints that we've found a way to prepare for and care for birth in a way that will turn the way we look at complication rates around.

Success has to be better than chance. Success in an external cephalic version is 55 percent for breeches turning head-down. Success in reducing the cesarean rate is noted when the rate lowers a percent or two! I'm hearing Spinning Babies® is making a measurable difference in birth outcomes. To me, success in matching a technique means the next phase of labor comes within an hour or two, or a baby. Your colleagues come running to implore you to do "that thing you do!" Doctors take you aside and ask what it was you did that enabled them to cancel the cesarean. You'll learn a process that you can do in 15 minutes to two hours. Begin your preparation with a sense of connection in your body. Check to see that you are yourself in a nurturing state.

The power of the provider's words is, to an astonishing degree, a leaven for the manner in which the parent's brain imprints nurturing behavior for their baby.

This is why the presence of a doula and other aspects of social support improve birth outcomes more than heart rate monitoring. The birth environment, and the way labor is managed, also influence birth hormones. The first step of the International Childbirth Initiative is *Treat every woman and newborn with compassion, respect, and dignity, without physical, verbal, or emotional abuse, providing culturally safe and culturally sensitive care that respects the individual's customs, values, and rights to self-expression, informed choice, and privacy.* Social aspects of support turn up birth hormone levels like a placenta. Protecting those levels is as crucial in birth and early parenting as it is in early pregnancy.

Love is chemical, Lou Reed once sang.

And you, intrapartum care provider, hold the key to the lab.

Birth is then chemical. By the end of this book you'll have the solutions to dissolve the cesarean rate, labor and pregnancy pain, and labor dystocia. If you follow this process you may improve labor progress 70 to 80 percent of the time. Come to our advanced workshops to understand how to help another 20 percent. We don't expect 100 percent. We know rickets, intrauterine growth restriction, placental and cord emergencies, and nonphysiological reasons for cesarean still exist.

As you explore birth physiology, you begin to “see” what’s happening inside the body. Confidence in supporting physiological birth will grow and even become pleasurable.

## **Nurses Together**

Nurses come together to help each other. Today nurses are facing a pandemic of the coronavirus and challenges of caring for families separated and masked. Facing the cesarean pandemic is less deadly short term but is becoming more and more dangerous as the decades go by. Accreta, abruptions and stillbirths in subsequent pregnancies, infections and general mental anguish and distractions – all increased by potentially avoidable cesareans – are unfortunate inhibitors to early parenting and feeding. Nurses have had enough.

In many hospitals today, teams of two to three nurses or nurse-midwife-doctor trios have decided to take on stalled labors and failed inductions with Spinning Babies® at the bedside. The cesarean rate comes down. In several situations, with no specialized training, financial investment, or even physician backing, the grassroots application of Spinning Babies® has reduced hospital cesarean rates.

Here are stories of care providers using Spinning Babies®:

Valarie Martin, Tamara Schatz, and the nurses of PIH Health Whittier Hospital in Whittier, California, spoke with me at the AWHONN meeting in Long Beach during February 2020. The nurses had gone to the Spinning Babies® Website for ideas to assist posterior labors. Later, a few nurses paid for themselves to take our short workshop at Valley in Renton, Washington. Without a training for their full staff or midwives, the nurses were able to drop the cesarean rate from 37 percent to 7.9 percent on their best month. They now hold their cesarean rate at 18 percent.

Nikki Zerfas and Lorri Elliot are two intrapartum nurses at the University of Washington Medical Center. They advocated for the entire staff to get the Spinning Babies® training. Over 70 percent of the nurses attended one of four identical eight-hour workshops. Increases in confidence and use of physiological techniques were reported.

Before the workshop, 25 percent of these Seattle nurses felt “very competent” managing normal labor discomforts, and three months after Spinning Babies®, that number rose to 65 percent of UW labor and delivery nurses rating themselves as very competent. The “moderately competent” group increased from 37 to 75 percent, even three months out from the training. The 5 percent who felt very competent to resolve labor dystocia before the Spinning Babies® training

rose to 24 percent, even months afterward. One day of training multiplied competency nearly fivefold to solve labor dystocia, a leading cause of cesarean section, injury, and death in childbirth around the world.

Nurses felt they were better at their jobs when they were able to use intentional labor positions, such as those we show in Chapter 6, from 55 percent before training and 74 percent after. The nurses felt strongly that these positions helped patient satisfaction with their labor experience, growing from 55 percent to 79 percent with training. There were a few participants who didn't have patient interaction, and percentages were not adapted to reflect only nurses interacting with laboring patients.

Women themselves, voting with their feet, are the most powerful determinants of method of birth, of course. Neil Shah, MD, says it's which door a woman walks through that is the most important factor in whether she has a cesarean – not her health, dates, or baby size, but which hospital door she walks through.

In São Paulo, Brazil *every* door led to an operating room. Ninety-five percent of all the births in the huge city were surgical. It seems the only vaginal births in São Paulo were in elevators and taxicabs. Then the birth givers of Brazil used their feet to change the cesarean rate. Pregnant women painted their bellies and marched along their famous avenue, Avenida Paulista, and the cesarean rate dropped to 90 percent. While you pick your jaw up off the floor, consider the power of that very particular 5 percent change, 95 to 90 percent. It's rocked that nation past the inlet toward the direction of physiology.

Then a charismatic doctor and midwife team made birth world news by offering water births in a tiny birth center. It was like rediscovering human birth after a futuristic gap in reproductive physiology. Most Brazilian doctors didn't see a baby pushed out of a vagina, but only pulled through an abdominal incision. One obstetrician told me in 2014, when I first arrived, "Gail, Gail, I got my cesarean rate down to 66 percent!" Please understand that this doctor is made of pure courage. After a career that only occasionally included a vaginal birth, her resolve was significant! Better days were coming. Debra Pascali-Bonaro flew down with her movie, *Orgasmic Birth*, and Brazil lit like the Samba. And then Ana Cris emerged on the stage.

Maíra L. S. Takemoto, PhD, and Ana Cris Duarte, a pair of visionary midwives in Brazil, invited me to bring Spinning Babies® in the wake of revolution. During the very first workshop, midwives and doctors used their phones to text solutions to labors in process.

A survey to providers using Spinning Babies® in over 100 hospitals found no injuries, no bad outcomes. The reclaiming of birth by a growing movement in Brazil is one of Earth's bravest stories. This is a movement of the people.

In Boston, Massachusetts, the nurses and midwives of Newton Wellesley Hospital were inspired to bring Spinning Babies® Approved Trainer Lorenza Holt to lead them through the training necessary for a Quality Improvement project with Spinning Babies®. Here, everyone who was expecting to have a vaginal birth was given the full Spinning Babies® program of body balancing and birth smart positions. The team was graced with guidance from two great minds in public health. Boston University's Eugene Declercq, PhD, MBA, is a professor of community health sciences at the Boston University School of Public Health and professor on the faculty of Obstetrics and Gynecology at the Boston University School of Medicine. His current research focuses primarily on maternal mortality and morbidity. Gene wrote and performed "Birth by the Numbers" which can be seen on YouTube, said even a 2 percent reduction in the cesarean rate would gain the attention of the public health world.

Dr. Karla Damus is a Boston University Senior Research Navigator who leads the Research Navigator Team (RNT) and is a perinatal epidemiologist. Dr. Damus said in her career with BU, she signed every proposal on public health graduate studies. She spoke to me at a party at Lorenza's home which celebrated the Quality Improvement project. After thirty years, she said, she could retire. She'd been searching for something to reduce maternal mortality and she believed Spinning Babies® was it. I asked her to repeat that as I wanted to make sure she wasn't just saying a nicety. With her Ruth Bader Ginsburg-like manner of speaking, Karla Damus's eyes lasered into mine and right into my frontal lobe saying, "Yes, Spinning Babies will do more to reduce maternal mortality than anything else that's come across my desk. If I were just starting out, I'd base my career on it!"

Leslie Fung, MPH, of Newton Wellesley presented Newton-Wellesley's QI results at the 2018 National Association of Public Health Annual Association meeting. Lorenza, Karla, and Gene continue to support new research on Spinning Babies® in Massachusetts hospitals.

These are just a few examples from grassroots to the gestation of research.

The growth in popularity that Spinning Babies® enjoys is because midwives and nurses are bringing Spinning Babies® around the world. Midwives often have the autonomy and a bit more background in physiological methods – at least that is the expectation if not universally the

opportunity during school. Nurses have less autonomy so an effective approach that can fit their scope of birth positioning is tremendously empowering.

Used this way, the intent of nurses can and does transform a hospital labor culture. There is no us and them, no push against technology, only the adoption of a way to activate the body's own function. Lives are touched and communities are lifted. Nurses are an underrecognized solution to the horrendous cesarean rates of the world. Spinning Babies® empowers them where they are, at the bedside, with tools they have in every setting, their hands.

In the next chapter, we find out how this nonmedical way of saving mothers and babies came to be.



## **Chapter 2: “Why Won’t This Baby Come Out?”**

### **My Story**

Remember P. D. Eastman’s children’s book about the little bird who wandered the world looking for his mother? He even asked a steam shovel if it had seen his mother. Steam shovels had been reinvented by the time I read his book, but I cried for the little bird who sought solace from a cold machine. Where the hell did his mother go? What could she have been thinking when she left her little hatchling?

P. D. Eastman created a space to explore the real feelings felt by little kids during the separation from their mothers. Resolving separation anxiety was a journey, immense as it may be, but faced by every little bird. I shook my little pixie haircut and took on the task of avoiding it from the start. But to understand the impact of mother-baby separation, I had to understand the baby.

The first question to help me on the quest was to find out how did babies get here. There were 36 kids on the block across from my house. We were coming from somewhere. Down my block was a Catholic church, a convent, and school. It was 1964. My mother wasn’t Catholic or religious, so while my friends had all the answers, I was the kid who had all the questions.

I asked my mother. “Gail, don’t you remember? The stork brings the babies.” Her friends chuckled. It was the early ’60s; sex ed was yet to be considered.

“There aren’t any storks in Minnesota,” I said, leaving them to their cards. My next chance to ask was at my aunt’s house. “They come from under a cabbage leaf.”

“What? In the dirt?” Unbelievable! Again, I turned away.

I went to my best friend Shawn’s mother. She just had new twins and that made five daughters under six years old. I figured she’d know where babies came from, but my mother said that evidently, she did not. The good woman told me, “When a man and woman get married, God blesses them with a baby.” I drooped. I didn’t think God was on speaking terms with my parents. They were divorced.

My sister took me aside, “You know why people won’t tell you where babies come from?” My heart leapt! At last, the truth! “Mom and Grandma got you from the church rummage sale.” I was aghast. This was not at all what I expected! But it did explain the shame I saw cross the

grownups' faces whenever I asked where babies came from. No wonder no one would tell me the truth. I wasn't bought at the department store but on the leftovers table. Not new, but oh so cheap.

Trembling, I suddenly realized a more important question, "Did they pay a quarter, or... or," my little heart quaked, "only a nickel?" The wise elders of the small town of Lake Crystal, Minnesota, didn't throw nickels lightly, but they were the common price of used goods.

I hoped my mother and grandmother paid the quarter I knew I was worth. The odds weren't good. My grandmother rarely paid a quarter for anything without a motor, like a clock or radio. My sister skirted my question. I became convinced they had cleverly down-sized my worth to a nickel just to get the deal rather than paying for full quality.

Shawn was four and I was five. Her mother was the one who just had the twins. We were sitting in a young apple tree with Becky and Tracy, a pair of sisters from across the alley.

My small hand curled round a thin branch of the tree we sat in. Movement seemed to course under the smooth, green bark. I felt as if the tree offered a deeper conversation, and at five years old, I simply accepted the intelligence under my hand. We weren't allowed in the tree when Mr. and Mrs. Able were home. But Shawn watched them leave for the store. They were elderly. They didn't have children. And they weren't watching.

So Shawn gathered us together, and up we climbed. These girls had information I needed.

"The doctor cuts babies out of the mother's side," Tracy confided.

"No! That can't be true." I said with conviction.

"Oh, yes," Becky said. "I saw the scar. My mother showed me the scar the doctor made when Tracy was born."

Suddenly a rush of time swept over my five-year-old head, a gulf stream of air flowing back to antiquity. How, I don't know. Maybe it was the stack of Time Life books my mother provided us kids. I was still at the picture-gazing stage, picking out the easy words, fascinated by the drawings of human evolution. One remains a classic to this very day. That doesn't make sense, it felt wrong. How could birth depend on a knife? (I didn't know about scalpels yet.)

Continuing to disagree would only hurt the sisters' feelings, and it wouldn't help me understand birth. Knives and scissors weren't as old as when people started. Something felt so terribly out of sync, but I had no words for it. And so the question remained with me, *How are babies born?*

One neighbor was born too early. Melissa or Missy, her big sister called her. There were boys in the neighborhood too, but I played trucks or doctor with them, and we didn't discuss the origins of life. Missy was only about three and her sister nearly five. They lived in the farmhouse that had a barn but was now on the same lot size as the rest of the houses built on its previously sold-off land. They lived with Grandma Horn. Missy's sister told me that she was born premature, a word I had never heard. She was two and a half pounds at birth and was sent home to die. Grandma Horn didn't take to the doctor. She opened the oven door to take advantage of the warmth of the pilot light and placed Missy in a bed of cotton in a shoe box on the shelf made by the open door. For herself, she made a pallet on the kitchen floor from a folded quilt. And for the next two months, she fed Missy with an eyedropper every fifteen minutes, day and night, relieved by only short breaks of two hours to sleep now and then.

Now Missy ran around with us as we played. She was as normal as any child, and I saw no difference in her other than age. She was a little sister, and like we did with all the littles, we protected her from rough play. Otherwise she was active with us in every way. We ran to the three-season porch to sit on Grandma Horn's lap. She smiled at her granddaughters and then at me, their new little friend. We happily drove her to distraction patting her cheeks and playing with the rhinestones on her cat eye shaped glasses. Missy at one lens and me on the other. Her sister said, "We're Indian."

I'd never heard my teachers or parents speak of Indians still living in modern times. This was a surprise. "Where are your bows and arrows?" Hollywood betrayed us all again at that moment. Grandma Horn silently put me down from her lap and said it was time to go outside. I never saw her again. My professor at the University of Minnesota, Roger Buffalo Head, a Ponca who survived Andrew Jackson's invasion of Kentucky for gold and land by being born with a natural smallpox immunity, would help me to understand my offense – but my heart is ever broken. The poignant loss I felt for the elder with the queenly glasses, who knew how to keep her premature granddaughter alive, helped me remember these important lessons illumined by even a brief exposure to the light of her rhinestones.

## **Becoming a Mother**

Simple questions assume simple answers. I learned about eggs and sperm when I was eleven years old in the seventh grade. Not in a health class, but from a formula inked on the back

of a kid's green army jacket, probably written with a warning by the older brother who gave him the jacket. I happened to be in the hallway behind him. "Sperm + egg = baby": I'd found the answer at long last! Somehow the sperm and the egg have to get in contact. Oh my god, kissing can get you pregnant! This was a fascinating and a terrifying discovery!

Eventually I did find out how babies got made, very personally, on a gorgeous June night after a summer storm. It was during a detour I had taken to answer another question, *what* was the big deal about sex?

I loved pregnancy, I loved birth, and I loved being a mother. I went to the county hospital so I could have a midwife, but it wasn't until four appointments and four pimple-faced, embarrassed residents awkwardly doing pelvic exams as an excuse for prenatal care did I realize I had to restate my intention if I was going to get a midwife. I went back to the nurse at the desk and asked when I got to meet the midwife. The nurse looked at me with surprise and rushed to grab a midwife. Her movements gave me a feeling she was an advocate.

I had read *Spiritual Midwifery* cover to cover, and could name the babies whose pictures I saw and remember their birth stories from The Farm, a hippie commune in Tennessee. My sister had given me the book and said she'd take me there to give birth if I wanted. With the clouds overhead, I lay in the grass in my cotton dress reading the practical wisdom of self-made midwives working with Ina May Gaskin while my baby grew secretly in my belly. One day, I would visit there and meet some of the families and midwives in the book.

But then my sister found nurse midwives in a local hospital and signed up. My birth was empowering, but once I arrived, I took to the bed. The nurses were disappointed. Didn't I know I was allowed to walk? I didn't have to labor in bed. I shook my head and turned to my task.

My sister and I had entered the hospital at the wrong end, and I'd walked the equivalent of a couple city blocks before getting in the bed to be checked at 9:30 p.m. From 4 cm upon admission to fully dilated by 11:30 p.m., it was all I could do to focus and breathe. Pushing was another matter; his hand was along side his head that was to measure "adult size small" by two and a half years old. The kid had to be hard-headed. His mom was 17, living on welfare, and just became a vegetarian. Life was going to be a ride.

Back then, I was a mellow mother who was invited by friends to be at their births. My experience validated everything I believed. I wasn't savvy, but then neither was I judgmental. We went with the flow.

My sister and I both had natural births in the hospital. We had easy births in my family. At least that's how *we* interpreted them. My sister's second baby was direct occiput posterior but came fast. Her urge was to grab her husband's head under her arm and lift her leg in the air straight over his ear and up to the ceiling. To this day I can't quite picture it, but she assured me this was the only move that felt right. As soon as she got into it, the midwife caught my nephew.

A book caught my eye at the library. *Immaculate Deception*. Suzanne Arms wrote of the social disruption of separating families at birth and other issues with 1970s birth practices and presented the homebirth movement. Shortly after that, early in 1981, I saw she was coming to Minneapolis to speak to a grassroots homebirth group. I met the families and homebirth midwives. I volunteered to write the newsletter and began attending hospital births for neighbors and people who wanted a natural birth in the hospital.

I don't know the true diversity of the families I helped in those years. There are people who don't identify as she/her, though they are birthing from a uterus. I will say woman and mother for those that I heard use that title for themselves. I use parent, birth giver, and birthing person when speaking generally about the public and mother or mother-baby when describing anatomy and hormones. There seems to be a major shift in our use of gender language, but it is not universal at this moment. My commitment at this time is to nudge and explore the gender discussion as I play a birth educator role. My youngest, Gairm Abhuinn, and many of our new birth workers hold the torch for my own language shift, and I agree with the acknowledgment of nonbinary birth givers being included. I am also addressing millions who haven't shifted their language. There are various reasons they haven't, and it isn't my role to take that on. My choice of language in this book, rather, may be a first exposure to acknowledging the presence of birthing fathers, nonparent birth givers, and others whose identities are not the subject of this book. My interest is in reducing violence, harming words, and exclusion while maintaining a joy and appreciation for all family configurations.

When my oldest was six, and six years before my second was born, my friend Vicki was pregnant with her first baby. When it was discovered at 36 weeks that her baby was breech, a cesarean was scheduled for her due date. She was told she could expect a 10-day stay in the military hospital, and her husband, a military officer, wouldn't be allowed in to visit her or the baby. After dropping her off at admissions, he'd wait to see her and his baby when she came back to the

hospital door with the 10-day old baby in her arms. Vicki wasn't about to go with that plan. We were about to reroute the flow.

Her great-aunt had her first baby, who was also in the breech position, out on the farm. A veterinarian helped her. Vicki decided she'd stay home, too.

I packed up my boy, and we drove the five hours down to their city. We called midwives around the nation. We found one living just 40 minutes away. Each night I prayed, and each night I got the same message: Prepare to catch. No, no, I answered back, I'm going to be the photographer! But just in case, I studied each of the 10 nights I waited for her labor to begin. Paragraphs in chapters and little booklets gave us little to go on except a sense that breech birth could be done. The sources didn't let on how much more there was to learn.

Vicki found a doctor who tried to manually turn the baby until he and his assistant soaked their shirts with sweat and the baby's heart rate stopped. We froze looking at the ultrasound screen. Seconds passed. Then beat ... beat ... beat ... beat, beat. Vicki and her husband wept. The doctor said come back on Monday with insurance papers for a private hospital birth, if she could birth in four hours, he'd help her with a vaginal birth. If not, well, "what was the big deal about birth from below?" Vicki put her bet on Monday morning.

We drove back to her home with Vicki feeling bruised and decided for a hospital breech birth. The bruised feeling kept coming back. She got in her bathtub to see if she could relax. She brought in her beagle to lie on the floor, lit some candles along the bath, and sent her husband and me to watch the evening news. Like I cared what was on TV. Soon she called me back to the bathroom to say the maneuver must have hurt the placenta because the pain was getting worse. While she discussed arrangements for the dog while she went in for the now needed cesarean, I noticed her pains came every two minutes. A look of relief and realization swept her face. We called the midwife and boiled the water.

Soon, the ginger tea was steaming – it's wonderful smell in the air – and Vicki's mother passed me steaming washcloths to soothe her bulging perineum.

Still no midwife. I asked Vicki not to push. Not yet at midnight or at 1:00 am. We'd spoken with her a couple times and thought she was on her way. I was kneeling behind Vicki as she knelt, leaning forward over her living room table. A quarter past one, I was trying to tell top from bottom of what looked like a loaf of bread coming out of Vicki's vagina. *Spiritual Midwifery* was open

and literally tucked under her knee to keep the page open that showed instructional drawings of a breech birth.

Vicki's midwife arrived as the loaf of bread sprang open into two legs and a tummy with a pulsing blue umbilical cord. The two baby feet wiggled their toes in all directions. The midwife slipped to her knees beside me. "Are you ready?" I asked, I was still oiling Vicki's perineum and wiping baby poo – something we would never do nowadays, but back then oiling perineums was sacred. The counter support had helped Vicki cope before the baby crowned or, rather, before the baby "budded." I wouldn't have known when to stop.

I offered to get out of the way so the midwife could catch, and she declined, saying, "You're doing fine." I offered again. She shook her head no and smiled. My mind clicked. I realized I was catching the baby. Then the arms were out and a little face appeared with eyes wide open. Her 10-10 Apgar Score included a fierce cry that I imagined said, "Why wouldn't you let my mother push!?" Nothing I read gave any clue about the euphoria that would lift me for decades.

## **Beginning Birth Work**

When parents came to the birth gatherings in the 1980s and wanted a drug free, instinctual birth at a local hospital, the midwives wouldn't help them. They were busy caring for the families staying home for birth, and that's a lot of care. So, since I wasn't a midwife yet, I got invited to several hospital births.

Home or hospital, I got to be with women from the last weeks of pregnancy through early labor, and I would stay with them until an hour or more after birth. Breathing with their rhythm, I saw the similarities of these women's birth preparations. The intent for birth was just as determined. But the labors varied.

If a labor at home was long, I heard at the meetings, the midwife might take the mother to the hospital for the birth. A midwife would say the mother was too hung up. The vibration of the motor on the ride to the hospital, or the mental release from relief of being with authority figures were the reasons they assumed labor picked up. And if the person ended labor with a cesarean, then it was because she couldn't let go.

By contrast, I saw a lot of women start their labors with the same intent and the same determination. The difference eluded me as to why, when both were well supported and similarly dedicated, that one may struggle to give birth, whereas another let her baby slide out. I just didn't

see it the way the midwives did. I saw long labors in which the woman wasn't "hung up" but let herself go fully into the experience. Something else was happening.

Jan Hofer noticed my tactile abilities and very early on invited me to assist her and her midwifery partner, Jeanne Bazille, at a prenatal visit with a mom in her third trimester. They felt her belly while I stood to the side. Jan turned to me and asked if I would check to see if I could find one or two babies. The mother and two midwives looked at me invitingly. I wasn't sure if the question was rhetorical. I felt and then showed them how the baby on the right and the baby on the left mirrored one another. This was the mother's sixth and seventh babies so it was easy to feel through her abdominal wall to trace thighs, knees, and shoulders as well as the backs, bottoms, and heads. The look on Jan's face stays with me like whispering magic. I could see in her eyes that I had just done something more than expected. While they were wondering if there were one or two babies, my hands easily defined body parts and put the kicks and wiggles to images they could then see. I got invited to the birth as a reward. I was so new to assisting midwives that I had to practice squeezing the bulb syringe and woke in the night terrified I would accidentally squeeze air into the baby's lungs when I was supposed to suck mucous instead. How grateful I was when routine suctioning was abandoned!

"Pauline" asked me to come with her to the hospital to be with her second birth. The first labor finished with a cesarean. Her doctor had said, "Well, look at your hips, of course you needed a cesarean! Your baby was 9 pounds 12 ounces." If you are reading this from outside the United States, that is 4,423 grams. I hope you know that this is also ridiculous. The outer hip size is not the indicator of internal diameters. Birth position has a much higher correlation. Pauline poured out her hopes and dreams as we took walks around her neighborhood. She said, "I'm going to go into labor at night and give birth in the morning."

Labor started out as planned. In the afternoon, Pauline walked around her neighborhood stopping for contractions, first holding her belly, then holding a tree, and finally holding her husband's neck. As we went into the evening, she knelt over the back of the couch. We tried rocking the pelvis through the contractions. Eventually her frustration rose. So, in the middle of the night, she began walking up and down the stairs sideways and we explored existential questions such as should she go up leading on a different leg than she goes down the stairs with?

In the morning, labor contractions seemed just as moderate as the night before. The rhythm was hypnotic. As light came through the window, so did the sound of jackhammers removing the



neighbor's drive way asphalt. Her favorite kneeling position with her face out her favorite window was no longer comforting with the deconstruction 25 feet away.

She sat up with a bounce. "Let's go to the hospital. It's morning!" She literally said, "People have their babies in the hospital! Let's go!"

When we got there she was in good spirits. Having her cervix checked and finding out she wasn't dilating yet was upsetting. We got through the day by walking halls and once the stairwell. The sideways stair-stepping action stirred frustration as stairs hadn't been the trick the night before. As the second evening fell, so did her patience. "Why, why won't my baby come!?" She cried out to anyone who might know. I tried to comfort her and transmit a calm acceptance of her labor.

When the nurse heard her, "Your baby will come when your baby turns around." She described a posterior presentation to us. She explained that eventually the baby would turn. "Come, sit in the rocking chair. It'll be a nice change."

I listened to the nurse and remembered reading about posterior labors in Elizabeth Davis's *Heart and Hands*. I knelt beside her and slipped my hand between the slats in the back of the chair. Through the narrow spaces, I rubbed her aching back. Her husband and I swapped washcloths for her forehead and I rubbed her sacro-iliac joints. "Why, why won't my baby come?" erupted through the night. Then the midwife came.

"Come, come with me," she held her hand out. The mother moved as if asleep or afraid to hope. She cried she couldn't do it anymore. The midwife said, "Sit here on the toilet. We'll turn the lights off but let a little light in by leaving the bathroom door open a little." Pauline settled on the toilet. She seemed to let her muscles settle. Lights were dim, the space was private. "Now it's time to go into the unknown." The midwife continued. "Your mind isn't going to birth this baby. Feel the rhythm of your breath. Breathe in deep. Let it out. Let it go." Her voice was comforting.

On the toilet, Pauline could roll forward on her tuberosities, raise her shoulders, and let her belly hang forward. Her back was straight. Her knees angled down. Her pelvic floor could relax. No need to hold any sphincters here.

With this dark support, she went into the depth of her being. The midwife sitting close, being both comforting and entirely unyielding, helped Pauline let go. Contractions had been frequent but not strong. And then they came on. Three momentous contractions, three whoppers. The midwife gave a gentle nod of contentment. Pauline's wasn't the only body that relaxed.

There is a moment in birth that comes to the ears like song out of silence, or like the first tuning of the orchestra at Vienna's Ringstrasse or New York's Carnegie Hall. There is a thrill the listener gets in anticipation of what is to come. The first fleeting grunt. Another. A few more contractions, and she was guttural and soon roaring. With the midwife's encouragement, she took a few large steps to the bed. The end of the bed was closer to her. She couldn't take the time to come around to the side of the bed. So Pauline lifted her knee and crawled on the bed, onto her hands and knees, with the midwife following closely. Then suddenly, out slipped her second 9 pounds, 12 ounce baby! The matching size made her birth all the sweeter.

I drove home with my next question coming on as fast as the traffic. What can I learn about posterior labors to help the next person? When Pauline asked me to be with her, she expected me to know something about comfort measures and birth lore. I didn't know what to do as she called out again and again, "Why?" My reassurances were hollow. My skills, though they were the recommended moves, were lacking. I didn't want to feel so helpless again, and more importantly, I wanted to be able to respond effectively when a birthing person needed help.

## **What Makes One Birth Easier Than Another?**

Being with birthing woman after birthing woman convinced me it is not through psychology but rather through physiology that allows birth the ease birthing people seek.

By 1998, I found *Optimal Foetal Positioning* by Jean Sutton and her friend, Pauline Scott. My first response was wonder, and then I cried. Four births that year ended in cesareans that, with Jean Sutton's brim opening positions, were probably unnecessary.

That same year I met Penny Simkin, one of the founders of the doula organization, DONA International, then called Doulas of North America. DONA brought continuous peer presence to the mainstream of birth care and the doula enjoyed over 24 control studies. And birth became more peaceful.

I invited her to Minnesota to train us as doulas for a hospital that had asked the group of birth assistants I led since 1993 to offer the labor support for a project headed by Clinical Nurse Specialist Dorothy Walden Woodworth. From Penny, I learned the role of a nonmedically trained doula as a valuable peer at your birth, in addition to a midwife or doctor, and a lot of new birth moves that I and thousands of her other followers put immediately put into action at doula- and

midwife-assisted births. Our pilot project achieved a cesarean rate of 3.94 percent by having doulas and doctors working together on reducing surgeries.

In 2000, DONA met for their annual conference. Midwife Guadalupe Trueba and Doula Trainer Elena Carillo brought the Mexican rebozo in the spirit of cross-cultural sharing. The doulas were in love with and honored the gift of the rebozo. In time, use of another culture's treasures will be called on for cultural accountability, but in the year 2000, we simply celebrated. The rebozos were long and narrow, perhaps seven to nine feet long (about three meters).

Traditionally the cloth is woven by women with a pattern unique to their family and village. The rebozo has multiple uses, divine and mundane. The rebozo is worn as a shawl and used to carry a baby or groceries.

Skilled Mexican midwives use the rebozo in ways to help babies reposition in the womb. There's an issue with taking a cultural tool or technique out of the context of the culture. For instance, I don't recommend the US midwives or doulas imitating the Partera's repositioning of the baby with the snap of their cloth. Babies that are lying in a womb with a twist can face the opposite direction than the side their spine is on. Flipping the baby by jerking the cloth in these rare cases can turn the head further in the wrong direction. An experienced Partera can time a baby's heartbeat with their fingers, and they can palpate a fetal position accurately. Furthermore, the rebozo sifting, called *manteada*, is done after a thorough massage. Palpation accuracy in the US and Europe have been shown to be much lower than provider's estimate. This means as often as midwives and doctors think they know the position of the baby, the baby is just as often not actually in that position.

Extracting a tradition from a culture can deceive the taker that they can bring the full results with the item. Certainly benefits can be seen. But what is given in return? Receiving permission, acknowledging the lineage, and respecting the tradition is only part of it. Accountability includes protecting fair trade sources and the economics of the communities from which the items come but being in relationship. What seemed supportive in 2000 is redefined in the 2020s. At Spinning Babies® we seek to give back in more relevant ways for receiving benefits of the rebozo. Individuals make a culture, individuals break a culture, and it can only be individuals who rectify the harm done.

In 2002 a one-page website on Spinning Babies® was put together by a father of a VBAC baby. With nothing but a keyword, I began getting emails from parents and doulas. I had wanted

to check my theories out with my peers. I gathered my midwife and doula friends for a two-hour sampler course. In 2003, I left Minnesota and began to show birth networks the Spinning Babies® concepts. As of today, you are reading the results of hundreds of similar gatherings, and all that came of them, my births and theirs, and all the people I met and their contributions.

Spinning Babies® began with a mission to help posterior labors. I started with a cross-pollination of midwifery values, optimal fetal positioning, Penny Simkin's positions and doula training, and home birth midwifery-inspired birth positions and matched them all to where baby was in the pelvis. More would be added, but this is what I took to Seattle and L.A.

I repeated the doula training with Penny in 2003. It had been five years and I wanted an update. I was invited to introduce Spinning Babies® to the Pacific Area Labor Support doulas. Doula Trainers Guadalupe Trueba, Lorenza Holt and I stayed in Penny's home. They sang me the Mexican birthday song in Penny's kitchen. It was my best birthday ever. A decade later, Lorenza Holt would become one of our Spinning Babies® Approved Trainers when the voice of God said in my ear, "Invite Lorenza, she'll raise the bar in Spinning Babies®." Some readers may be wondering how to get selected as an Approved Trainer. You just need a similar referral.

As my presentation approached for the Pacific Area Labor Support (PALS), I realized I would be talking about my midwifery biased observations with Penny Simkin in the audience. She was one of the creators of the doula scope of practice. Teaching palpation wasn't going to be an option. Palpation, like cervical exams, leads to the questions about what does that fetal position mean to labor and perhaps a question of what to do next. In other words, diagnosis, and from diagnosis, management. So it's not that the doula can't touch the belly. Many pregnant people long to share the joy of the kicks and wiggles inside. It's the diagnosis that is outside the scope of the doula role. The peer relationship would be lost, and the mother wouldn't have someone at her side but another person in front of her. The word *obstetrics* means "in front of" but to make that location significant, there would have to be women at the birthing person's sides. And the doula, like a sister or another mother, is at the mother's side. (*Midwife* means "with wife," and as a midwife, I was most often physically *behind* a woman. I wonder what specific word would describe that position!)

How was I going to talk about fetal position without palpation? If the doula couldn't feel every curve and limb of the baby, the pregnant person could. I got to thinking fast and invented Belly Mapping® to substitute for palpation, and keep the expertise within the pregnant person to

self. Belly Mapping® uses not touch but a series of simple questions that the doula could ask the pregnant person. The pregnant person can also ask themselves these questions. The delights of Belly Mapping® do not lie in its accuracy; I'd guess it's about 80/20 in accuracy if there isn't an anterior placenta. But the beauty of Belly Mapping® is in the bonding. Parents become more attached to the womb-baby as the Belly Mapping® process leads to their visualization of a real baby. Oxytocin heaven!



Today the ultrasound scan is common. A pregnant person sees the baby on the screen at several times in pregnancy. Yet it is one's own touch of the baby inside that awakens the tactile connection within oneself and the baby within. Penny liked it. I could help doulas and parents answer the question, "After three days of labor, why didn't anyone know my baby was posterior!" But the nurses and midwives used the tips to help increase confidence in their palpation.

Presenting to Penny and her community further organized the concepts and use of Spinning Babies®. The approach was then a mix of midwifery values and labor tips, relaxation with one or two rebozo techniques, and several labor positions to help a baby into and through the levels of the pelvis. It was about to get an upgrade.

The doulas loved Spinning Babies®, but in 2005, the midwives began showing up in regular numbers. In the summer of 2005, the number of breech positions seemed to go up. The pregnancy routines, however, were not working so fast as they did before. It was like a page was turned. Was it lifestyle? There may have been metabolic changes due to an epidemic of low thyroid, but whatever caused an increase in breech position, it was noted by many midwives in casual terms. There were more babies having posterior presentations as well.

I went to see Penny every year at the DONA Conferences. She always asked new and provocative questions in her presentations. “What don’t we know about occiput posterior positions?” It was hearing her question, “Do you know what to do for the classic 7 cm stall?” that I first found out there’s a thing, at 7 cm, that indicates a challenge. Can the labor be resumed, or will a cesarean be needed? I’d watch for the things she posed, learn to identify it in a labor, and work out a way to address it. I’m indebted to Penny’s wise questions. I’d wonder.

I sought answers that were not in books but were right there next to me all along. I’d stand next to a woman and say to myself, “If my body felt like her body, what would be happening inside?” Once I put together a plan for the stall at 7 cm, I could take another question. I learned to see it wasn’t the dilation, per se, but the anatomy in the pelvis that was holding up the baby. Question after question, our informal student-teacher study style developed Spinning Babies® into a centimeter-by-centimeter, almost a step-by-step, system through the bony pelvis.

Once near the end of a talk on posterior myths, Penny said, sort of philosophically, “Now somebody should do something on asynclitism.” And so I went on a quest to figure out what to do about asynclitism. I noted I needed to find something more than the side lunge. Meeting Carol Phillips was key to that “something.”

Dr. Carol Phillips was a local chiropractor well into developing her soft tissue treatment protocol, Dynamic Body Balancing, and she was generous in sharing with midwives. She’d taught chiropractic at Northwestern and treated disabled children in children’s hospitals in Europe. Her angelic presence and unique treatments benefited many normal pregnant parents and their children, as well.

In 2006, Carol invited me to a workshop on pregnancy and newborn protocols. Going beyond craniosacral and myofascial therapies, Carol adapted soft tissue unwinding.

During class, Carol called me up to demonstrate standing sacral and in two seconds put her hands gently around my right knee and asked me what had happened there. “Nothing,” I said, and she looked at me with an expression as if to ask, “Don’t you know?”

Just as I was falling asleep that night, I started laughing. *Nothing!*? Oh, you mean, when I went down the stairs at 11 months? My leg gradually twisted so the scar left across my knee cap moved off to the side. By the time I was seven years old, the doctor suggested metal braces on special shoes to help my legs straighten. So yes, something did happen to my right knee. Spinning Babies® body balancing portion of the approach is heavily influenced by Carol’s work.

I knew I had to stop Birth Doula Training workshops and put my attention to Spinning Babies®. But just then a midwife I admired and loved left the hospital for a homebirth practice and invited me and a student to join her. Clare Welter, Emme Corbeil, and I formed Trillium Midwifery and went to home births together. Clare introduced me to yoga, and Emme later came and worked with us in the office at Spinning Babies® when we met near her home.

Back in the ’90s, Jan Hofer and I attended an half dozen breech births at home. But by the time Nickie Kerrigan started learning midwifery and attending births with me, we used Carol’s Dynamic Body Balancing from Carol and watched babies turn head down, sometimes literally seeing the inverted belly bounce with the turning baby.

I used that time with fewer breech births to devise a methodology for resolving shoulder dystocia. Home births in Minnesota include a higher proportion of nine- and 10-pound babies. If only one out of 10 10-pounders has a shoulder dystocia you still have more than the average hospital rate of shoulder dystocia. Studying posterior labors and how babies rotate to anterior taught me a lot about the physics of shoulder dystocia. My understanding of pelvic diameters strengthened, and I began teaching maneuvers as they relate to pelvic level. Penny and midwifery author Anne Frye encouraged me. I refined my presentation and made a video class including my memory tool, FlipFLOP, by 2009. “Resolving Shoulder Dystocia” is now one of my online courses. That complete, I went back to my first love.

In 2009, I went to the Ottawa Breech conference. Learning from the spatially gifted breech experts Frank Louwen and Jane Evans, breech birth came back into my work. I now had their insights for what I was observing and applied my knowledge of the pelvic diameters to systemize the observations with the pelvic diameters at the three main levels of the pelvis; inlet, middle, and outlet. The organizers of the England Breech Conference shared a film of a complicated breech

birth with the audience of breech experts, or Breechies, and asked for insights at the unusual descent of the baby. The room was silent. Daring confidence, I came to the front and described the labor obstruction through the view of the “pelvic level solutions” with a doll and plastic pelvis.” I could show the chin on the sacral promontory with the doll while we saw the outer effects on the particular shadows on the perineum. They said the usual maneuvers didn’t work and I could demonstrate why not and show why the obstetrician’s final insightful move freed the baby, and just in time. Another highlight of the “breech years” was being invited overnight with Mary Cronk, who gave me a personal seven-hour class on breech variations. My train had been late, and we stayed up until 2:00 a.m. In the morning, during breakfast, she showed me her famous kitchen drawer. When you attempt to open a drawer, she explained, and the implements tangle with the cabinet so that the drawer won’t open fully. Do you pull? No, because the implements get jammed tighter! Rather, you close the drawer a little and wiggle the implements. That sorts the tangle and the drawer opens just fine! Another highlight was sitting 10,000 feet above the ocean with Jane Evans as we flew back to the United States refining her and Mary Cronk’s descriptions of breech cardinal movements.

To put full focus on Spinning Babies<sup>®</sup>, I said goodbye to primary midwifery in 2011, with the birth of a mother whose own birth I attended in 1986. The moment was doubly special with the appearance of a hidden twin, a breechling. Being with the same family to complete the cycle of my midwifery is a gift beyond coincidence.

My work with Spinning Babies<sup>®</sup> took me traveling far too much. I keep involved in birth by helping out now and again. One of those years included seven breech births. To continue my commitment to breech birth as my midwifery slowed to occasional support of other midwives, I approached Nicole Morales with a vision of her future breech work. I could see that she would teach breech with the paradigm and perception I wanted to support. She thought I was a bit optimistic as she hadn’t yet caught a breech baby. I smiled. She, too, have been referred to me. Then the California midwife board voted to defy their midwives their constitutional right to assist homebirth parents with breech babies without a physician in charge. Neither Nicole nor I saw then how she was going to walk her path; I only saw that she would. Soon enough, Dr. Stu Fischbein began asking her to assist him at breech births when in her area.

What Penny Simkin saw in 2003 was a way of seeing birth that didn’t exist before. She told me then that I was before my time, but my time was coming quickly.



## **Birth of a New Birth Paradigm**

A paradigm is all the ways we explain the world we see and how we come to see the world in the way we explain it.

Fetal position, labor patterns, and labor progress are dependent on the tensegrity (the tension between opposing pulls) in the fascia, the web of fibrils wrapping and bridging the birth anatomy. These structures are muscles, ligaments, joints, and the connective tissue overall and through all these same structures. What's tight or twisted can be corrected, or balanced, in pregnancy or even in the moments of birth. Not for everyone, but for most!

My teachers were each person in their unique birth. The standard answers I received didn't seem any more correct in 1984 than the answers I got in 1964. I heard the doctors and midwives say:

“The baby was big.”

“She was too uptight.”

“Sometimes there is no reason. It was meant to be.”

A hypothesis tests a theory about the reality within which you will use the theory. If you keep asking questions that reflect an agreed reality, you may only be strengthening what is already assumed. We circle around a popular premise. When my questions arose far outside the cul-de-sac of sanctioned education, new answers could emerge. Some of those answers were ancient, some from bodywork, which also has ancient roots. By 2017, new research on the fascia was validating hundreds of years of traditional techniques. Not having gone to midwifery or nursing school was actually my advantage in paradigm shifting.

We are drawn into any paradigm by social agreement first: to be accepted by parents and peers. Humans are raised to think a united way with their identity group, then educated to agree with valued ideas (think evidence-based).

A paradigm is like a perceptual, or mental, map of the world. It's how we arrive at conclusions and how we make decisions. If our paradigm is accurate, we find our ways to solutions and interaction that fulfill our expectations. But if our paradigm isn't accurate or is biased, we miss the fullness possible with a better paradigm. To empower parents, we needed a way to bring the message of Spinning Babies® to parents and to the providers who serve them.

During this budding adolescence for Spinning Babies®, the first group of Approved Trainers joined me in San Diego. The catalyst was Tammy Ryan of Iowa, a doula trainer and an initiator. She believes she can, so she does. In this simple but glorious way, Tammy started the new cycle of my life and work. Again a voice spoke in my ear, “Tammy is going to ask you a question and your answer will be yes.” Only this time the voice was that of Debbie Young, DONA board member, friend, and doula co-trainer with Tammy. I said yes. Bringing on Approved Trainers added the community I longed for. Here was a group dedicated to the message, to teaching, and to one another.

To grow a strong community with a clear sense of purpose and paradigm, I planned three international conferences at two-year intervals. My trainers have my back. But sometimes it’s hard for them to grasp my vision. The first conference was, according to doula and stage manager Chris McBride, “All the cake ingredients thrown in the air and landing fully baked, and not only that, but decorated!” Participants said it was the best conference ever and many said, “It’s because nurses and doulas, doctors and midwives, bodyworkers and educators are all sitting together. They are hugging in every session.”

Chris had quickly become a best friend and was suddenly my event doula, too. She came to the conference twenty days ahead and stayed awake with me each night. With Chris and Melissa now sharing the load with my conference crew of local friends, I decided I had just enough time to create two booklets, The Spinning Babies® Quick Reference Guide and Breech Basics. So in our spare time during the two weeks before the conference, Chris doula-ed me through two books. Our spare time not preparing the conference was from 11:00 p.m. to 4:00 or 5:00 a.m. Our day started again at 8:00 a.m. By the time the Approved Trainers arrived, Chris was like the exhausted doula at a long birth that is delirious to see the midwife arrive. The “midwife” was Jennifer Walker, Approved Trainer and Doula Trainer from Amsterdam. Chris exclaimed, “Good, you’re here! I’m going to bed!” Chris wanted to be rested when the “pushing” began!

Jennifer intuitively got my vision. I called her my interpreter. She helped the Trainers and crew to understand me and me to understand them. Jennifer continues to interpret the vision between myself and my team in our company leadership. Jennifer and Melissa also had previous theater production roles so they and Chris were unflappable.

Jennifer Walker envisioned the path to empower parents through one-on-one relationships in hands-on pregnancy classes and would become the director for our Certified Parent Educator

Program. Our first parent educator training happened during the winter storm in 2018. Lorenza Holt, Rachel Shapiro, and I launched the Certified Parent Educator training. Jen couldn't attend at the last minute, but Chris came with Phyllis Klaus, for whom she became a personal and administrative assistant.

I became passionate in 1977 to recognize the baby's awareness of their birth experience and first greeting. Phyllis Klaus, another DONA founder, author, and world-famous therapist, wrote the *Amazing Newborn* with her husband, Marshall Klaus, MD, who with pediatrician John Kennell (also DONA founders) coined the very word *bonding*. Phyllis's life work includes overcoming and avoiding birth trauma. We met through DONA, and she supported Belly Mapping® as a way to assist parents to connect with the baby while still in the womb. Her therapy work involved hundreds of hypnotic regressions to people's birth memories. Babies are aware of everything and parent and provider's emotions and actions interpret their worth and welcome in life at this moment. Phyllis shared ultrasound video of babies imitating kisses, copying chewing, and batting their hands towards their parent's fingers tapping on the surface of the abdomen. Life in the womb seems more aware of us than we of them. The point was that babies readily interact with parents. Unknown to the adult world, babies are learning and in relationship at all times. The Klaus's' work on parent perception and the power of skin-to-skin bonding has transformed hospital practice. From the launch of our program, Phyllis kept the baby's experience central and my life's motivation was brought full circle.

In 2019, 14 Approved Trainers gathered at Lake Superior adding two nurses and seven midwives from six countries attended. The late Claudia Booker was in cancer treatment and unable to join us. They are my Spinning Babies® hive mind.

In maternity care, the paradigm shapes our practice decisions. In business, structural change is a radical reorganization. For a person with an idea, installing a business structure to support that idea demands radical change in their thinking. From midwife to business owner is not an intuitive leap, but demands relentless chiseling of assumptions and habits. From business owner to team play is yet another session with a hammer. Or, to use a birth metaphor, shifting one's sense of self to allow one's vision to appear is like dilating into transition – again and again and again – before there's enough descent for others to see your work.

The pandemic actually gave us a chance to stabilize and grow our office team. All the moving parts of the business are nurtured now. I would shout out my team names but for their

privacy. The Approved Trainers have a very public role, so they are defenseless. But I have one person in the operations you'll see if you order a physical item. The emails from my shipping department are signed, "From Vic, Gail's husband and shipping guy".

During 2020, the successful work to bring about a new business team allowed us to support a new role. Rhea Williams, CNM, soon to be Dr. Rhea Williams, PhD, Approved Trainer and our Director of Professional Education and Development to create our hospital training program. Rhea's role will allow us to serve intrapartum care units with transformational support. Our Spinning Babies® goal is that 30 percent of birth care providers will begin interventions with a physiological technique first. A feeling of completeness comes over me now that Rhea is in her position. Some of the biggest dreams of all feel possible with everyone in their seats and we are reaching our goals in spite of the restrictions of the pandemic.

Rhea Williams and Nicole Morales dream with me to fulfill my late friend and advisor Claudia Booker's vision of making the Spinning Babies® paradigm accessible to who Claudia called, "Birthworkers of Colors." Our commitment to an expansion of protected intellectual property with our branded trademark is unique from typical ways of business and has to be crafted with and by BIPOC leadership. Not charity or socialism, but neither capitalist market growth can fulfill the shared creation we seek.

"If you want to make minor, incremental changes and improvements, work on practices, behavior or attitude. But if you want to make significant, quantum improvement, work on paradigms," Stephen Covey says while teaching principle-centered leadership. Find this quote in his book, *The 8th Habit*, on page 19.

To make the quantum improvement, hospital administrators have to come out of the tug-of-war with the two pressures on hospital practice:

1. To seek to reduce the cesarean rate
2. To justify a high cesarean rate

To get out of the dualistic dead end, they need a third place to stand. This might be a paraphrase, but Einstein's principle told us that the structural thinking that got us into the high cesarean rate can't be the same thinking that raises the spontaneous vaginal birth rate. Practices that separate women from their physiology can't attain the true measures of successful care, spontaneous onset of labor, high vaginal birth rates and low use of pharmaceuticals and instruments, skin-to-skin contact and breastfeeding success that comes from skin-to-skin contact.

Dr. Dick-Read once said, “We cannot obtain normal reactions by the production of abnormal states.” I’d expand his meaning to include the production line of birth and its effect on the nervous system of the birth giver.

Finding solutions for posterior presentations improved birth outcomes that support skin-to-skin contact and a mother gazing at her newborn. Gaps in my knowledge about the posterior position motivated me. I learned that mothers had the desire to give birth even when labor was long. I learned skills to support health during a long labor from homebirth midwives. I learned birth positions to shorten labor from Penny Simkin, and later, the writings of Blandine Calais-Germain.

What was missing up to that point was both how to identify when labor was off track before vital signs slipped and how to pick the right birth position more often. This is the *when* and the *how* of choosing birth positions. My quest led me to a better understanding of pelvic diameters. Never in history had a physician or midwife come up with an inlet to outlet system of assessing and addressing labor progress and certainly not by activating birth anatomy.

Honoring the limits of the Doula Scope of Practice demanded creative new ways for teaching doulas how to perceive the fetal position and the signs and signals of labor progress. It was by virtue of this limitation that I created systems of assessment and resolution available to the doula. These systems turned out to be extremely valuable to nurses and midwives in intrapartum wards. It delighted me to find this also meets the needs of midwives and nurses who are not being served by the vagueness of vaginal exams.

Soon, I would see the value to the pregnant person, their partner, children, and extended family. Having on-lookers at a baby fair watching Belly Mapping® turn to belly painting raised the oxytocin, the love hormone, to a community level.

My story seeks to free all mothers and babies from the harms of separation. Paradoxically, freedom came through my own limitations. By not having surgery to rely on, I found the solutions in anatomy. By not having a medical or midwifery education I could learn from observing births without interpretation as to what I could perceive or not perceive. And by not being able to fly in 2020, I could write this book!

The little bird of P. D. Eastman’s children’s story may find that freedom within structure is the key to changing the world.

This is the End of the First 2 Chapters of Changing Birth on Earth, by Gail Tully, CPM and

Creator of Spinning Babies®

[www.SpinningBabies.com](http://www.SpinningBabies.com)

We hope you have enjoyed the first 2 chapters of Changing Birth on Earth. This book will be available for purchase on Amazon mid-October 2020.

## EARLY REVIEWS

How can we honour the intelligence of our birthing bodies to promote a smooth, safe labour and birth? What skills and techniques might help when labour is not progressing?

Gail Tully shares her vast knowledge and ground-breaking Spinning Babies perspectives, providing simple, safe and practical techniques that all birth workers can use to facilitate a physiological labour and birth. Highly recommended.

Thanks so much for all the love and determination you have poured into this book. Your work is truly ground-breaking



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Gail Tully's beautiful book, Changing Birth on Earth could not have arrived at a more important time. As we struggle with a global pandemic and complex challenges to our values and uncertainty in our lives, this book helps us to remember and resonate with the power of love, empathy, human connection, healing, and the miracle of birth.

Gail wants those caring for birthing parents to "dance into work." I find Gail's love and belief in our human capacity to give and support birth to be source of hope and strength. She invites nurses and midwives to "love your job more" and come with her to a "better birth world, " and to "lead from the bedside" In this world nurses and nurse midwives have the knowledge and

skills outlined in the B.I.R.T.H process. This process is grounded in the physiology of birthing with exquisite attunement and respect for the uniqueness of each birthing person and their loved ones. The results of the B.I.R.T.H process is a significant decrease in cesarean section rates – and, in adapting this approach, “you could possibly bring the cesarean rate down by half in two to three months.”

This is big. And yet there is more. Why does it matter so much?

In Gail’s words, it matters “Because of the look on the mother’s face. Because the baby was born alive and alert. When a baby is able to go directly to their parent’s arms, immediate contact imprints the memory of a loving welcome rather than the stressed sleep of separation. The point isn’t happy memories, the point is beginning life with intact attachment behaviors.” Gail articulates an inspiring vision in these words: “we’re heading toward a birth that is not a fearful emergency but a future emerging.” Changing Birth on Earth provides a clear guide, loving support, and stories that illuminate the how and why for bringing physiological birthing to life in our health care organizations. I believe this book can fundamentally transform our paradigm for the birthing experience and optimize outcomes for mothers, babies, and their families. Brilliant.

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