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Risks And Benefits Of Hospital Procedures

By Yvonne Lapp Cryns

In spite of all the advertising touting "home-like" birthing rooms in hospitals, for most women, a

hospital birth will be nothing like a home birth. Interventions are routine in the hospitals in my state. Every laboring woman will be hooked up for some period of time to an electronic fetal monitor, given vaginal exams, and be told where and in what position she must give birth. If her membranes are ruptured, she will be required to deliver her baby within a certain time period. If her labor is moving too slowly, she will be given pitocin to augment it or have her water artificially ruptured. She will be told how many companions she may have with her. If she has other children she may or may not include them at the birth. How long she is kept in the hospital will vary depending on her physician and the particular hospital. How soon her baby will be released also will depend on the baby's pediatrician and hospital policy. Some of the more common interventions that take place during hospital births are discussed below.

AMNIOTOMY

Artificially breaking the amniotic sac is done routinely at many hospitals to speed labor up, get labor going, to test the fluid or to get it out of the way so that an internal monitor can be screwed into the baby's head. It was believed that breaking the water would speed up labor by 30 to 60 minutes but the only randomized control trial done disproved this. This procedure causes cord prolapse, a serious complication for the baby and increases the chances of an infection. With less amniotic fluid in the uterus during labor, the baby has a greater risk of cord compression problems leading to fetal distress and malpositions of the head. 1, 2

DRUGS & EPIDURALS

Nearly every woman giving birth in a hospital will receive a drug at some point during her stay. Pitocin is frequently used to induce or augment labor. Because it causes abnormally strong contractions, many women receive a pain-relieving drug such as a narcotic. Unfortunately, narcotics also are received by the baby and can affect the condition of the baby at birth and for years after. Some of these side effects are respiratory problems, impaired muscular, visual and neural development in the first week of life and in the following years, lower reading and spelling scores, difficulty in solving problems or

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performing tasks when they pose a challenge.

The new drug of choice at many hospitals is the epidural. It must be administered by an anesthesiologist and requires the mother to remain in bed afterward. She must be flushed with an IV fluid prior to getting it to keep her blood pressure up. A needle is inserted into the woman's back and small catheter is left in place where the medication is injected. It numbs the woman's body from the ribs to the toes. Many women ask for this drug because they do not want to deal with the pain of childbirth and believe it is safe for themselves and their babies because the physician who administered it, their obstetrician and the labor and delivery nurses all encourage the use of it and give no information regarding side effects.

The known complications are many ranging from requiring EFM, IV, immobility, urinary catheterization. An epidural also may allow no sensation of labor or the pushing urge, lower blood pressure, abnormally relax the pelvic muscles which may encourage the baby to adopt malpositions of the head,

may decrease the production of oxytocin at critical times, and increase the need for forceps and cesarean section. Epidurals cause some serious complications such as heart attack, spinal damage, and spinal headache. After the birth, chronic backache is a common complaint as well as backache. The baby may be exposed to narcotic drugs given to enhance the effect of the epidural and which if given alone can compromise the baby's respiratory efforts as well as require the newborn to metabolize the drugs. We do not know the short or long term effects of the epidural or other drugs on the baby. Some claim that the baby is unaffected unless the mother becomes hypotensive. Some non-interventionist birth attendants recognize that occasionally epidurals may be useful for certain situations. Some examples when an epidural may permit a normal birth are for maternal exhaustion, severe back labor, certain malpresentations or psychological dystocia. Although the FDA approves drugs as safe or unsafe, they have no definition of safe and do not guarantee safety of drugs. Many who work with brain damaged children, wonder if the disability is due to obstetric drug use. They also question if women would make the drug choice if they were given complete information about side effects. The American Academy of Pediatricians discourages the routine use of obstetric drugs. 3, 4, 5, 6, 7

ENEMAS

This procedure is still done routinely at many hospitals, although no research proves any benefits for the mother or baby. Home birth and natural birth advocates recognize that for the vast majority of women, the process of labor will empty the bowels. 8, 9

EPISIOTOMY

Although many believe that an ep[isiotomy is necessary to have a baby to prevent damage to the baby's head, prevent trauma to the mother's perineum and the cut will heal faster and prevent 3rd and 4th degree tears, no research supports these myths. Shiela Kitzinger writes that 9 out of 10 American women will have an episiotomy with her first baby although in Holland, only 2 or 3 out of 10 will. The facts are that episiotomy is a cultural phenomena. Research shows that episiotomy is done because the doctor was trained to do it, not because it was a necessary procedure. It can be avoided by using

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more physiologic positions to give birth (not lithotomy), pushing only when mom feels need to, giving birth gently, slowly to the head, preparing for the birth by doing perineal massage and Kegel exercise, avoiding forceps delivery. 10

FORCEPS & VACUUM EXTRACTOR

Forceps are obstetrical tools which are shaped like large spoons have been in use since the 1500's. Years ago, forceps were used for many problems which are now handled by cesarean section. Today, most forceps deliveries are low forceps, which means they are applied when the babies head is low in the pelvis and birth is imminent. According to Henci Goer, "There is no research to support the elective use of forceps."

The risks to the mother are perineal trauma, extensive episiotomy, possible extension tearing from episiotomy, hematoma and nerve damage. Lasting effects of forceps or vacuum extraction to the mother may be anal incontinence in spite of a repaired third degree tear. The baby may have damage to the head, eyes, the nerves that lead to the face and neck and arms. However, an article written by a physician which appeared in Parents magazine claims, "Medical studies comparing outlet forceps deliveries with spontaneous (no forceps) deliveries have shown that there is no difference in risk to the baby." (Emphasis mine)

Vacuum extraction is a newer technology that sometimes takes the place of forceps. As with low forceps, the baby's head must be very low in the pelvis before the suction cup can be attached. It has the benefit of not requiring an episiotomy and maternal perineal trauma is less than with forceps, but the baby still has the possibility of trauma to the head and face. Chiropractors also recognize that pulling a baby out by the head changes the spinal alignment, although this is not recognized in any medical texts. 6, 11, 12

IMMOBILITY

Along with the lithotomy position comes immobility. It is impossible to move around when you are flat on your back. It's even more difficult if you have internal and external fetal monitors attached to your body, an IV running into your arm and after a narcotic drug was given to "take the edge off." It goes without saying, that if you had an epidural, you would not be going anywhere at all as your legs would have no feeling.

Some hospitals encourage walking and moving around. Others do not like you to be out of your room, which may be quite small and loaded with equipment, making any real walking about nearly impossible. Studies have shown that moving about and being upright can shorten labor as well as changing positions. 13

INDUCTION

According statistics from the health department in Wisconsin, one-third of all births in that state are the result of induction, the artificial starting of labor. Most inductions are accomplished using pitocin in an intravenous solution or artificially rupturing the amniotic sac. The reasons for doing this are many. One

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of the most common for healthy full-term women, is fear of going too far past the "due date" and having a baby with postmature syndrome or meconium staining. Another reason is fear of having a big baby.

Benefits of inducing would seem to be avoiding postmature syndrome, attempting to deliver a baby that had grown too big for the mother and bypassing meconium staining. However, studies fail to confirm this line of thought. The actual amount of time needed for a baby to grow to term varies and figuring an exact due date for each baby has not yet been done. Ultrasounds have at best a 10 day window of error if done in the first trimester. The phenomenon of postdates, is poorly understood. Macrosomia occurs prior to postdates as does "postmature syndrome." (p. 181) The entity of postmature syndrome is based on a single physician's "subjective evaluation of 37 babies." Research seems to indicate that watchful waiting is the more prudent course of action for healthy women. 14

IV

At a great many U.S. institutions, one of the first items of care to be rendered to the obstetric patient will be her IV, "just in case." Just in case she needs drugs or surgery or her veins collapse making insertion of an IV impossible. Nancy Wainer Cohen and Lois Estner interviewed many labor and delivery nurses to find out how frequently a laboring woman's veins collapsed. They learned that this does not happen. This is not the way birth happens in other nations, where a laboring woman is permitted to eat and drink lightly. This cultural warping began in the 1940's when anesthesia was being given to nearly all birthing women by mask and vomiting and food aspiration were risks associated with this. Eliminating food and drink, they felt would eliminate this risk. Today, however, anesthesia methods have improved and this is no longer the problem it once was. Improved intubation techniques make this problem virtually a thing of the past. Doris Haire, a maternity care writer, in looking at 20

years of medical literature on aspiration during surgery found that the cause was not eating or drinking prior to the surgery, but caused by incompetence of the anesthesiologist.

General anesthesia is given to approximately 4% of those who undergo cesarean section. Approximately 0.3% cesarean surgeries will require intubation that will be difficult to do yet not all women who require intubation will aspirate. This translates into denying all laboring women food and drink because 1 cesarean sectioned woman out of 10,000 may aspirate.

Although IV's are supposed to keep the stomach empty, a glucose IV actually works to slow down the emptying of the stomach. It also may encourage tissues to swell so that it makes it more difficult to intubate, if that becomes necessary. IV fluid accumulates in the bladder and that may slow down labor. Some women may have sensitivities to the IV and have a reaction from one. It restricts the woman's mobility. The needle in the arm is painful and inhibits free movement. The baby also may suffer from the mother's IV, as studies are being done to determine if the excessive sugar administered through a glucose IV may harm the baby. 14, 15, 16

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Robotics In Medicine - Improving Procedures And Reducing Costs

By Jules Andersen

Find out how robotics is a rapidly expanding portion of medical treatments.

Robotics in medicine is producing great results in many ways, especially in the area of surgery. The term robotics means the use of a robot to perform various functions. A robot has movable physical structure, a power source, a sensor system, and a computerized "brain" to control activities.

Surgeons of the future will use robotics to perform surgical tasks. Robotics still requires the expertise of the surgeon to operate, but the instruments used by robotics improve the control, the precision, as well as often minimize the invasiveness of surgical procedures.

Robotics is being used for things like gall bladder surgery, endoscopy, and many other surgeries. Basically, here's how robotics surgery works. The surgeon looks into a viewfinder to see images being sent by a camera that's inside the patient. Images show the surgical site and the surgical instruments. Controls, much like a joystick are used by the surgeon to manipulate the instruments and perform the surgery.

Patients with robotics surgery have smaller incisions, shorter hospital stays, and normally faster recovery time. This reduces costs and gives the patient the ability to return to normal activities in a much shorter time span.

Surgical procedures aren't the only place robotics can be used in medicine. Developers are continuously working on new ways to allow robotics to perform tasks. One area that's especially promising in the control of disease and the prevention of diseases being spread. Areas that could be harmful for hospital personnel can be sterilized by using robotics. Some other types of procedures are sterilizing floors, delivering lab specimens, pulling patients on stretchers to rooms.

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Advocates of using more robotics in medicine feel that the benefits far outweigh any negative constraints. However, in some instances the question of the patient's emotional state has been questioned. Most people feel more secure when being transported by a human than having a robot transport them. There are other instances where human interaction can have a positive effect on the patient.

How far will the loss of human interaction go in the medical community? At this point, it seems there will be little attention paid to the humanistic side of using robotics in medicine. Obviously, in areas where the patient is virtually unaware, as during surgery, there is little reason not to employ robotics.

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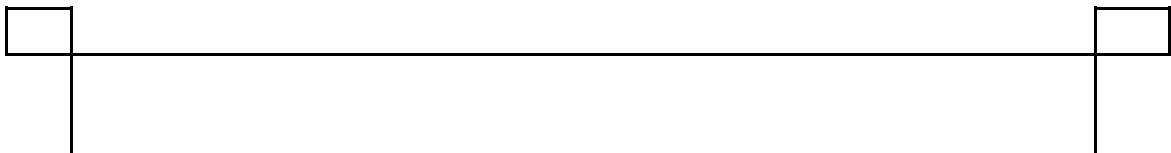
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for more on robotics in healthcare, robots in the

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