They Said So on the News: Parsing Media Reports About Birth

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ABSTRACT

In this column, the authors reprise recent selections from the Lamaze International research blog, *Science & Sensibility*. Each selection discusses shortcomings in the news media coverage of childbirth issues. The authors demonstrate how to identify misleading claims in the media and highlight how childbirth educators can apply a common-sense approach and careful fact checking to help women understand the whole story.

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These days, women are exposed to a proliferation of media about pregnancy and birth: More health or pregnancy magazines are available on the newsstands; 24-hour news channels on the radio and television increase the opportunity for health reporting; and stories are passed around at an unprecedented pace via e-mail and social media sites such as Facebook.

Along with the increase in access to news comes a simultaneous decrease in news quality. A 2009 survey of health journalists commissioned by The Kaiser Family Foundation revealed troubling trends affecting the quality of health reporting (Schwitzer, 2009). Journalists overwhelmingly said that budget constraints have seriously hurt the quality of health coverage, and that pressure to break a story first leads to fewer opportunities to conduct thorough research before filing a story. Respondents felt this leads to more “‘quick hit’ stories” (p. 9) about new treatments or technological breakthroughs rather

than in-depth coverage of health-care policy and complex health issues. Nearly half (44%) of staff journalists participating in the survey said that their organization sometimes (33%) or frequently (10%) based stories on press releases without substantial additional reporting. And perhaps most shockingly, 11% of staff journalists said that their organizations sometimes or frequently allowed advertisers, sales staff, or sponsors to influence story selection or content.

With more and more news media covering pregnancy and, at the same time, displaying a general decline in the quality of health news reporting, childbirth educators frequently find themselves answering questions about misleading or incomplete news reports. How can childbirth educators and other birth professionals evaluate the quality of news reports about pregnancy and birth? And how can we work to improve the health literacy of childbearing women who consume news media?

All too often, media reports of studies are based on a press release alone, and the reporters never see the real study.

Lamaze International's research blog, *Science & Sensibility*, is intended to help childbirth educators and other birth professionals gain the skills necessary to deconstruct the evidence related to current birth practices. Visit the *Science & Sensibility* Web site (www.scienceandsensibility.org) to stay up to date and comment on the latest evidence that supports natural, safe, and healthy birth practices.

Amy Romano, host of the *Science & Sensibility* research blog, invites readers to respond to the posts reprinted in this article. Go to the URLs presented in the corresponding footnote for each section's main heading and post your response.

Lamaze International's research blog, *Science & Sensibility*, frequently covers items in the news. For this column, three recent blog posts were chosen to demonstrate shortcomings in the news media and highlight how childbirth educators can apply a common-sense approach and careful fact checking to help women understand the whole story.

STRAIGHT TO THE SOURCE¹

Reports of new research studies can be found almost everywhere on a daily basis: on the nightly news, in mainstream magazines, in forwarded e-mails, on Facebook and Twitter feeds. But can these reports be taken at face value?

Let's look at a few examples:

First, a small blurb published in *Reader's Digest* in February 2007:

Fresh flowers can cheer up any drab room—not to mention score points with your sweetie. But make us kinder as well? So says Harvard psychologist Nancy Etcoff, PhD.

She sent 54 people either a mixed bouquet or a candle in a hurricane glass. Flower recipients said they felt more compassion toward others than those who got the candles, and reported more enthusiasm at work too. Place blooms in the kitchen or bedroom so you'll see them first thing in the morning. That's when moods tend to be lower and blossoms can provide their biggest boost. (para. 1 and 2)

This sounds like a very official, authoritative study. It comes from a "Harvard psychologist" and even details a little about the methodology. However, I searched pretty extensively and was not able to find that it had been published in any academic journal. The researcher, who is an instructor teaching one class at Harvard, does not even list it as part of her published research on her Harvard Web page. The study is, however, extensively touted on the Web page of the Flower Promotion Organization and the Society of American Florists, which includes as part of the study "documentation" an article by an interior designer on where to best place flowers in your home. To me, this brings the study

into some question. Who paid for the study? Was it commissioned by one of the organizations that exist to convince people to buy flowers? If so, there is a possibility of a bias in the methodology or conclusions. It's difficult to evaluate a study that has not been published. Why was it not published? I am left with more questions than answers, and I'd hesitate to place too much faith in this study.

As I suspect in this case, all too often media reports of studies are based on a press release alone, and the reporters never see the real study. Press releases are written in a way to make headlines, not necessarily for complete accuracy, and reporters under a deadline don't always do much more than use the facts in the press release.

Another example, taken from my local newspaper, under the title "U. Study: You Are What Mom Ate":

A new study by University of Utah neonatologists indicates that a mother's diet during pregnancy plays a significant role in whether her offspring develop chronic illnesses later in life. And these nutrition effects, known as "the unpleasant womb syndrome," can be observed two generations down the line. ("U. Study," 2009, B2)

Wow, pretty interesting findings, aren't they? Well, tracking down the actual study turned out to be difficult (you can read about it at www.lythgoes.net/birth/SearchingArticlePart2.html), but when I did, it turned out to be a study on rats. Yes, rats. The newspaper article, with its references to "you" and "Mom," implied that the research was done with humans, but in fact it was animal research. Results from animal research may or may not be applicable to humans.

In another article from *Reader's Digest*, the author lists a bunch of research findings about the potential harms of vitamins, among them this claim: "Researchers at the National Cancer Institute [NCI] found that men who took more than one multivitamin daily had a higher risk of prostate cancer" (Samuel, 2007, "Wild Claims," para. 5). However, the author oversimplified the NCI report in a way that can be easily misunderstood. To quote from the NCI report (Lawson et al., 2007):

We found that multivitamin use was unrelated to overall risk of total and organ-confined prostate cancer. (p. 761)

The possibility that men taking high levels of multivitamins along with other supplements have

¹Posted by Andrea Lythgoe on September 15, 2009, at <http://www.scienceandsensibility.org/?p=601>

increased risk of advanced and fatal prostate cancers is of concern and merits further evaluation. (p. 754)

A subtle difference, true, but also an important one. Multivitamins did not affect the overall rate of prostate cancer, or of the subgroup of cancers that have not spread. High levels of vitamin use (more than 7 multivitamins in a week, combined with other supplements) may have had an effect on the more rare, advanced forms of cancer.

That word “possibility” is very important. It signals that there is a gray area here where something has not been proven or disproven, but could go either way. It may be that vitamins and supplements contribute to the aggressiveness of cancers, but it also may very well be that they don’t. That’s why the authors recommended further research. When you read the word “possibility,” think of it as a hypothesis—a guess—something that should be researched further.

In this study, researchers had a fairly small number of people with advanced cancer—only about 1/10th of the numbers they had for localized cancer. This makes it hard to draw strong conclusions about the advanced cancers. Yet those conclusions are the very thing that the popular media article focused on!

These kinds of issues are fairly common in the popular media. Remember, the writers and reporters at the various magazines, newspapers, or Web sites aimed at the general public are likely *not* trained in reading and understanding research. With this lack of knowledge, they are likely to make easy mistakes, such as broadly generalizing and not picking up on subtleties like the prostate cancer article.

With a little education and a careful reading of research, you can skip the mainstream media, learn to read the actual studies yourself, and avoid pitfalls like these.

DOES IT? REALLY? “WHO ADMITS: THERE IS NO EVIDENCE FOR RECOMMENDING A 10–15% CAESAREAN LIMIT”²

This is the title of a *Medical News Today* piece (Coalition for Childbirth Autonomy, 2009), actually a reposting of a press release from a coalition of Web sites that promote elective cesarean surgery. The press release claims that the 2009 edition of the World Health Organization’s (WHO’s) *Moni-*

toring Emergency Obstetric Care: A Handbook (WHO, 2009) has rescinded its 1985 recommendation that cesarean rates not exceed 10%–15%. Can this be true? Not so much.

In fact, not at all.

The handbook still reads, as it always has: “[One of the six indicators of emergency obstetric care is the] estimated proportion of births by caesarean section in the population is not less than 5% or more than 15%” (WHO, 2009, p. 5, Table 2).

The press release goes on to state that the WHO “updated its 1985 [actually unchanged] recommendation on caesarean rates, admitting that ‘no empirical evidence for an optimum percentage’ exists, an ‘optimum rate is unknown,’ and world regions may now ‘set their own standards’” (Coalition for Childbirth Autonomy, 2009, para. 1). The material from the WHO (2009) handbook is accurately quoted so far as it goes, but it doesn’t go very far. The handbook states that “a growing body of research... shows a negative effect of high [cesarean] rates” (WHO, 2009, p. 25) and cites studies in support of this. The handbook continues:

It should be noted that the proposed upper limit of 15% is not a target to be achieved but rather a threshold not to be exceeded [emphasis added]. Nevertheless, the rates in most developed countries and in many urban areas of lesser-developed countries are above that threshold. (WHO, 2009, p. 25)

In other words, countries with rates under 15% should not be striving to increase their rates, and countries “setting their own standards” means determining optimal rates, which may vary, *within the WHO range*.

This brings us to the second flat-out untruth: The press release states that rates above the 10%–15% range recommended by the WHO have not led to a “concomitant rise in maternal mortality or foetal, perinatal and neonatal mortality” (Coalition for Childbirth Autonomy, 2009, “Background Information,” para. 3). The WHO supports the 15% upper limit precisely *because* cesarean rates above the 15% ceiling result in higher maternal and perinatal death and morbidity rates. Following are the studies they cite.

Deneux-Tharaux, Carmona, Bouvier-Colle, and Breart (2006)

This French study determined maternal deaths directly attributable to cesarean surgery by excluding

²Posted by Henci Goer on October 30, 2009, at <http://www.scienceandsensibility.org/?p=483>

Shame on whoever is behind these Web sites for circulating such dangerous misinformation without spending two minutes to fact check its accuracy.

To view the Today show's September 11, 2009, segment titled "The Perils of Home Births" (originally titled "The Perils of Midwifery"), go to <http://www.msnbc.msn.com/id/21134540/vp/32795933#32795933>

women with risk factors that could lead to the need for cesarean surgery and reviewing the confidential reports generated after each maternal death. "After adjustment for potential confounders, the risk of postpartum death was 3.6 times higher after cesarean than after vaginal delivery. . . . Knowledge of the causes of death associated with this excess risk informs contemporary discussion about cesarean delivery on request" (p. 541). The analysis, moreover, undercounts cesarean-related deaths because investigators excluded deaths that might have arisen from complications that occur more often in women with prior cesarean surgery, including ectopic pregnancy and deaths from hemorrhage due to placenta previa, placental abruption, and placenta accreta.

MacDorman, Declercq, Menacker, and Malloy (2006)

Investigators in a U.S. study found that after isolating an ultra-low-risk population with no indication for cesarean, babies born after cesarean surgery were 1.8 times more likely to die than babies born after vaginal birth. This amounted to an excess of about 1 per 1,000. The researchers concluded: "Understanding the causes of these differentials is important, given the rapid growth in the number of primary cesareans without a reported medical indication" (p. 175).

Villar et al. (2006)

In a report on Latin America derived from a WHO 2005 survey of maternal and perinatal health, Villar et al. found:

Rate of caesarean delivery was positively associated with. . . severe maternal morbidity and mortality, even after adjustment for risk factors. Increase in the rate of caesarean delivery was associated with an increase in fetal mortality rates and higher numbers of babies admitted to intensive care for 7 days or longer even after adjustment for preterm delivery. Rates of preterm delivery and neonatal mortality both rose at rates of caesarean delivery of between 10% and 20%. (p. 1819)

In other words, 15% is a liberal and probably overly generous maximum.

Shame on whoever is behind these Web sites for circulating such dangerous misinformation—but even more shame on *Medical News Today* for passing it on without spending two minutes to fact check its accuracy.

HOME BIRTH: THE REST OF THE STORY³

As most readers of this blog are probably already aware, the NBC network's *Today* show televised an inflammatory piece about home birth that parroted the American College of Obstetricians and Gynecologists' (ACOG's) long-standing scare tactics and anti-midwife rhetoric.

Since I just wrote a post on the safety of home birth, I thought that rather than repeating the same old story that *home birth is safe for healthy women with qualified attendants and access to referral*, I would share with readers some other thoughts, culled from this blog, the rest of Lamaze.org, and other trustworthy resources.

One of the first posts I wrote for *Science & Sensibility* (actually written as a guest post at Lamaze International's *Giving Birth with Confidence* blog while this site was getting up and running) was titled, "Why the Largest Study of Planned Home Births Won't Sway ACOG" (Romano, 2009). ACOG prefers to hold home birth to a standard of evidence to which hospital birth was never held. Even while actively compiling the lowest form of evidence on the supposed "perils" of home birth in a membership survey, ACOG repeatedly calls for a randomized controlled trial comparing perinatal death rates in the two settings, fully aware that such a trial is literally guaranteed never to happen. I discuss some of the reasons why in my post, concluding that we face much more urgent research priorities for the study of planned home birth than a full-scale clinical trial.

We need more and better research on home birth. We can use data from the Netherlands to determine the safety of home birth in systems that support and integrate home birth midwifery. After all, it is the only place left with a maternity care system that lends itself to home birth safety research, and national registers to conduct that research soundly. In the United States, we must study how we can

³Posted by Amy Romano on September 11, 2009, at <http://www.scienceandsensibility.org/?p=578>

reform our maternity care system to provide access to midwife-led care in all settings, and best practices for caring for the women who rightly and inevitably will continue to desire birth at home. (Romano, 2009, para. 12)

Why exactly do women desire to birth at home? It's not because they are hedonistic or selfish, as ACOG likes to suggest. Judith Lothian, PhD, RN, LCCE, wrote recently about the qualitative research she presented at the 2009 Lamaze Conference. Lothian asked women why they planned to give birth at home, and then observed them doing so. Their responses describe motivations far from reckless desire and hedonism. She writes:

I was surprised that all of the women described themselves as "mainstream." They all wanted a natural birth. All the women came to believe that "intervention intensive" maternity care increased risk for them and their babies. They valued the personal relationship with their midwife and believed that this relationship increased safety. They believed they could manage the work of labor more easily and more safely in their own homes. They all expressed confidence that a hospital and skilled physician care were available if needed. "Being Safe" emerged as the theme that captured the essence of women's decision to plan a home birth. In stark contrast to the current thinking, that birth is safer in hospitals under the care of an obstetrician, these women believe that giving birth at home is safer for them and their babies. (Lothian, 2009, para. 4)

It seems likely that women believe that home birth is safer than hospital birth because word is getting out that hospitals routinely deprive women of the style of care that is proven to produce the safest, healthiest outcomes. Lamaze recently released the third revision of the Healthy Birth Practice Papers, a collection of evidence-based articles about the care practices that ease and facilitate labor, prevent complications, and protect breastfeeding and early mother-infant attachment:

1. Let labor begin on its own.
2. Walk, move around, and change positions throughout labor.
3. Bring a loved one, friend, or doula for continuous support.
4. Avoid interventions that are not medically necessary.

We must study how we can reform our maternity care system to provide best practices for caring for the women who rightly and inevitably will continue to desire birth at home.

5. Avoid giving birth on the back, and follow the body's urges to push.
6. Keep mother and baby together—It's best for mother, baby, and breastfeeding.

The 2006 U.S. *Listening to Mothers II* survey revealed what anyone who advocates for home birth could tell you even without the data: Almost no one who births in a hospital actually experiences these care practices (Declercq, Sakala, Corry, & Applebaum, 2006). The survey found that fewer than 2% of women had all five of the care practices that the survey measured. (The practice they were unable to measure was "no routine interventions." Since interventions are routine and rampant in hospitals, this likely means that the proportion of hospital birthing women who experienced all six care practices was effectively zero.) Instead, the authors of the survey tell us what is happening in current, hospital-based maternity care:

"The data show many mothers and babies experienced inappropriate care that does not reflect the best evidence, as well as other undesirable circumstances and adverse outcomes. This sounds alarm bells," said Maureen Corry, executive director of Childbirth Connection. "Few healthy, low-risk mothers require technology-intensive care when given good support for physiologic labor. Yet, the survey shows that the typical childbirth experience has been transformed into a morass of wires, tubes, machines and medications that leave healthy women immobilized, vulnerable to high levels of surgery and burdened with physical and emotional health concerns while caring for their newborns." (Masciale, 2006, p. 2)

To view each of the six Lamaze Healthy Birth Practices and to read about the evidence-based research that supports these practices, visit the Lamaze Web site (www.lamaze.org).

In fact, ACOG themselves acknowledged in a press release that the current style of obstetric practice (high-tech defensive medicine) "ultimately hurt[s] patients" (ACOG, 2009, p. 1).

I continue to believe that if hospitals provided the six Lamaze Healthy Birth Practices as the standard of care and offered evidence-based treatments for women and babies experiencing complications, hospital birth would be safer and so would home birth. That's because midwives would initiate

transfers with more confidence that it would improve the outcome, women would transfer more willingly, and care at the receiving facility would be safe and effective. What's not to like about that plan, ACOG? Now, let's make it happen!

REFERENCES

- American College of Obstetricians and Gynecologists [ACOG]. (2009, September 11). *Press release: ACOG releases 2009 medical liability survey*. Washington, DC: American Congress of Obstetricians and Gynecologists. Retrieved November 30, 2009, from http://www.acog.org/from_home/publications/press_releases/nr09-11-09.cfm
- Coalition for Childbirth Autonomy. (2009, October 29). *WHO admits: There is no evidence for recommending a 10–15% cesarean rate*. Retrieved October 30, 2009, from <http://www.medicalnewstoday.com/articles/169058.php>
- Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2006). *Listening to Mothers II: Report of the second national U.S. survey of women's childbearing experiences*. New York: Childbirth Connection.
- Deneux-Tharaux, C., Carmona, E., Bouvier-Colle, M. H., & Breart, G. (2006). Postpartum maternal mortality and cesarean delivery. *Obstetrics and Gynecology*, 108(3, Pt. 1), 541–548.
- Lawson, K. A., Wright, M. E., Subar, A., Mouw, T., Hollenbeck, A., Schatzkin, A., et al. (2007). Multivitamin use and risk of prostate cancer in the National Institutes of Health–AARP Diet and Health Study. *Journal of the National Cancer Institute*, 99(10), 754–764.
- Lothian, J. (2009, July 31). "Being safe": Making the decision to have a planned home birth. Message posted to <http://www.scienceandsensibility.org/?p=373>
- MacDorman, M. F., Declercq, E., Menacker, F., & Malloy, M. H. (2006). Infant and neonatal mortality for primary cesarean and vaginal births to women with "no indicated risk," United States, 1998–2001 birth cohorts. *Birth (Berkeley, Calif.)*, 33(3), 175–182.
- Masciale, E. (2006, October 19). *Press release: Technology-intensive childbirth is the norm for great majority of primarily healthy women*. New York: Childbirth Connection. Retrieved November 30, 2009, from http://childbirthconnection.org/pdfs/LTMII_pressrelease.pdf
- Reader's Digest. (2007, February). *The power of flowers*. Retrieved November 23, 2009, from <http://www.rd.com/advice-and-know-how/the-power-of-flowers/article33037.html>
- Romano, A. (2009, April 15). *Why the largest study of planned home births won't sway ACOG*. Message posted to <http://www.givingbirthwithconfidence.org/?p=271>
- Samuel, N. (2007, November). *The vitamin myth. Reader's Digest*. Retrieved November 23, 2009, from <http://www.rd.com/living-healthy/are-vitamins-really-that-good-for-you-/article46647.html>
- Schwitzer, G. (2009). *The state of health journalism in the United States, March 2009*. Menlo Park, CA: The Kaiser Family Foundation. Retrieved November 23, 2009, from <http://kff.org/entmedia/upload/7858.pdf>
- U. study: You are what Mom ate. (2009, April 19). *The Salt Lake Tribune*, p. B2.
- Villar, J., Valladares, E., Wojdyla, D., Zavaleta, N., Carroli, G., Velazco, A., et al. (2006). Cesarean delivery rates and pregnancy outcomes: The 2005 WHO global survey on maternal and perinatal health in Latin America. *Lancet*, 367(9525), 1819–1829.
- World Health Organization. (2009). *Monitoring emergency obstetric care: A handbook*. Geneva, Switzerland: Author. Retrieved November 23, 2009, from http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf

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