Embracing Nature's Path: The Power Of Natural Birth And Personalized Care Transcript

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Introduction and Birth Topics

Welcome back to ADHD, Autism and Chronic Disease Parenting Summit. I am here with one of my favorite OBS, doctor Stu Fishbein, who is the host of the Birthing Instincts podcast.

Fantastic speaker. Always pushing the envelope. Speaking his mind. I'm really excited to chat with you today about a couple of topics within, you know, the birth, birth world.

Thanks. Thanks for having me. Do you want me to call you Doctor Joel Gaiter? What do you want me to call you? Well, whatever. It doesn't matter. I've been called much worse thing, so any of those will be just fine.

Okay. Okay. Well, thanks for having me on. It's a privilege to be able to reach any audience, so I'm. I'm thrilled that you're doing this. Well, thank you.

So, I mean, I want to start talking a little bit about, you know, the kind of current situation with the rising rates of inductions and caesarean sections out, for sure.

You know, preface it sometimes it's absolutely needed. I mean, having C-sections is a magical thing that we can save babies that we we couldn't before.

Sometimes you need an induction for a baby who's getting really big. They can't get out. You know, there are certain reasons why you might want to, you know, you don't necessarily need to, but but the reasons that people will do it.

So I guess that the first thing that I want to chat with you about was some that was very interesting to me, because going through my, you know, birth journey for my own kids, both of them were late.

Both of them were getting to the point where the the OB was starting to recommend. Hey, you know, it's getting closer to two weeks, you know, maybe want to think about induction?

We didn't end up having to do it for either one, thankfully. And things started normally. But one thing that was recommended to us, which I thought was really interesting, was castor oil and I had never heard of before.

I looked into it. There was a ton of research on it there, a meta analysis that showed that's helpful. And yet and I, as an integrative doctor, never heard of it.

It was never offered to us. And I just thought that was so interesting and maybe just, a little microcosm of everything that we're seeing, you know, in medicine these days where it's like there's this simple, you know, five cent thing that could potentially work versus, oh, let's go to the hospital and give you an IV drip, and a medication for five days, but, oh, there could be symptoms with, with cancer.

Also, we should be aware about the diarrhea versus like, well, you're getting an IV and a medication for 12 hours. Like which one has worse side effects.

So what what are your thoughts on on on that I'm curious. I think you've summed it up pretty pretty clearly. I didn't know about castor oil in my medical training at all, but once I started working with midwives, it became obvious that it's very well known to work.

I have seen it work, very well in women that are sort of going into labor or about to go into labor. I don't see it work

real well with women who are being induced at 39 weeks, for whatever reason, against an unfavorable cervix, that sort of thing.

Castor Oil and Natural Induction Methods

But if a woman is getting overdue and maybe they combine it with a cervical sweep, which is where they do a vaginal exam and they try to, cause a little irritation down there, because when you can cause, separation of the membranes, not breaking the water, but separating the membranes from the cervix and, and stretching things a little bit, it it releases the body's own natural prostaglandins and prostaglandins is cervical wiping agent which the hospital will then bring you bring you in and keep you in there for 12 hours with something in your vagina and, you know, cost you a lot of money to do that.

And there are ways to do that at home also. Semen has prostaglandins in it too. So you can mix all those things together. And when you do them all and add castor oil.

Yeah. I've seen great results. I saw the paper that you posted, on Instagram, and the success rate was, was quite high. And you're right. Why not do it in the ultimate reason, I believe, is one, it's not pharmaceutical and you don't make any as much money from it as you just said.

It's a five cent, 20%, whatever it costs for an ounce of castor oil or two ounces of Castrol mixed in with a smoothie, isn't something that that they can quantify.

And my experience with the medical world, having been in it for a really long time and then having gotten sort of, out of it and seeing both worlds, is that doctors fear birth.

They they want to control the process. They see it as a medical indication. You know, they look at pregnancy itself as a high risk condition, and therefore it's a problem and needs to be treated.

And so they come at everything from this point of view. And the midwives see things completely differently. They see birth as a normal process that occasionally, as you said in the opening, needs help at the hospital.

But that's a very small percentage of of moms. And the idea that you need to be induced because you're over 40 weeks or because you think you have a big baby, or they think you have low ish fluid, those things are really not even indications for induction in most cases.

And even the American College of ObGyn, which I have a lot of disagreements with, but some of their guidelines are very clear. And and it's very interesting to see, Joel, how the medical model will cherry pick the guidelines they like and ignore the guidelines they don't like.

And this is something that goes on in your, you know, with the American Academy of Pediatrics as well. So and what's going on with C-sections? I mean, it just seems like it's becoming almost normal at this point.

It's like, oh, you know, I don't really want to have to be inconvenienced by not knowing when I'm going to give birth. So I'm just going to schedule my C-section again.

Obviously, sometimes it's needed, sometimes there are emergency, sometimes there are medical reasons to do so. But it seems to me as a as a pediatrician and just as somebody out in the world and seeing friends, that it's become much more, I don't know, normal air quotes that, you know, schedule your C-section just just because and people are not really taking into account that it's a surgery and it's not the natural way to give birth, that there are potential complications, risks, long term side effects for the baby.

Like what? What what are you seeing and why do you think this is happening? Well, all medicine is filled with a lot of what I call stage one thinking.

And I took that from Tom sole, who's a economist. He's been a mentor of mine. He's retired now. But stage one

thinking is thinking about something that might do good or feels good.

But they never asked the second question, which is and then what will happen? And C-section is a great example of that. When you mess with Mother Nature, there will always be ripple effects, will always be downstream consequences, whether they happen immediately or whether they happen six months from now or six years from now, there will be downstream consequences.

And we need to look at those things before we just automatically instituted something that changes the way Mother Nature designs it. In fact, it's it's not nature that needs to to prove itself to be safe and effective.

It's the intervention that does. And yet medicine is filled with times where they introduce things without ever, analyzing what's going to happen if we do this.

And two of those things. There are many reasons why the C-section rate has gone from 5% 50 years ago to over 30% now. That's a 500% increase in cesarean section.

And the whole purpose was they thought to try to decrease the rate of stillbirth or cerebral palsy, or hypoxic ischemic encephalopathy in babies. And they have found that actually they haven't really done that.

We aren't really doing significantly better now than we were doing in 1970 when it comes to those things. Yet the C-section rate has risen that much. And two of the major factors for that were stage one, thinking things that the medical community did.

One was the institution of continuous fetal monitoring, which was where a woman wears the belts for the entire time they're labor, you know, for nine months they're pregnant.

Nobody's listening to the baby's heart rate. They're laboring at home for maybe six, seven, eight hours before they come to the hospital. Their doctor tells them, come to hospital.

Nobody's listening to the heart rate. Suddenly you get to the hospital. You have to listen to the heart rate constantly. And I won't get into the nefarious reasons why.

I think that sometimes these things are propagated, but money's always involved. The other thing was something called the Friedman curve. And I have a real beef with the Friedman curve, because the Friedman curve standardizes.

And boy, does medicine like standardization. They don't like outliers. They don't like individualization. It bothers them terribly. They like algorithms.

And the Friedman curve is a curve where women who are they separate them into women who are having their first baby, which we call privates, and women having their second or more baby vaginally, which we call multiples.

And they have a curve, one for each category.

Why C-Sections and Inductions Keep Rising

And the the prime curve is designed to say that women should dilate at least a centimeter an hour once they reach active labor, which in those days was considered four centimeters.

And in order to determine whether someone is dilating at that rate, you have to do something called a vaginal exam. And vaginal exams do many things, but when they interrupt the mother, two, they're uncomfortable, and three, they introduce the possibility of infection and they don't actually benefit anybody.

But you can't have a curve without points. And that's a geometry thing. So they have to have points on a curve. And then they decided that anyone that was dilating less fast than as that needed to be, augmented, needed to be sped

up.

And this is another thing that that bliss and I on the podcast we talk about all the time is why the need for speed, and, and in the medical model, they, for whatever reason, think that labor should be speeded up and why.

And that is another stage one thinking thing. I mean, obviously there are cases and we always put these caveats in where a woman needs to be delivered because she's got preeclampsia or whatever else.

But, but, but to speed things up is is man's desire. It's not nature's design. Nature does things for a reason in certain ways, and pretty much everything the hospital does prior to augmenting or intervening interferes with a woman's ability to go into labor.

Naturally. Because most mammals, when they go into labor, want to be safe, quiet and unobserved. And the hospital is the worst place. Well, to be quiet and unobserved.

I mean, some people feel that safety is there because they have an operating room or they have medicine or an anesthesiologist and that's fine. But safety isn't defined by everyone the same way.

So what happens is, is they've led down the path to this, this rising intervention rate, which leads to, dysfunctional labors, which leads to C-sections.

And then you can add in the descaling of obstetricians in taking away their ability to use forceps or to do a breech delivery or confidence with twin delivery and breech in twins, makes up makes up 6 to 7% of the term population, and most doctors will section all all of those.

So that's automatically right there. And then there's been a discouragement of vaginal birth after cesarean. Even though again Acog says that be back especially after one single low transverse Assyrian section or even two is perfectly acceptable and actually should be honored.

It's an ethical choice and therefore a hospital should honor that and doctors should honor that. But yet doctors do. Hospitals will have policies against it, and doctors will skew their counseling to get a woman to be scared about it.

And she'll end up choosing a C-section, which is better for the doctor, because when you do a C-section, especially a scheduled one, as you know, you know exactly when it's going to start.

You know exactly how long it's going to take, and you may get paid a little bit more. And if you even if you don't, you you save money in time because you're in and out in 45 minutes or an hour.

And, the hospital makes more money, so the hospital has no incentive to lower the C-section rate. And I don't see, unless we start returning confidence to the medical students and residents, we're training and the skills and we change the liability system, and we change the reimbursement system that there's any hope of the C-section rates falling.

I just don't see it. I want to I want to turn in the last couple of minutes. I really want to talk about home birth with you because I think that's a really, you know, interesting topic and something that definitely is getting a little bit more buzz lately.

I think people are opening their eyes a little bit more to the natural world, but certainly not, you know, enough. And especially coming from a general pediatrics world, you know, I can I can say very definitively that most doctors, patricians are very scared for whatever reason of home births.

They half the time don't even want to take patients that had a home birth for a month. I, I don't really understand that, but I've definitely had patients call that said, you know, they're interviewing wherever and they told them they're going home birth and that they won't see them for a month.

So they want to see, you know, where we're comfortable with that. So I was hoping you could dispel some of the rumors around home birth, maybe talk a little bit about the safety statistics that there are.

I mean, obviously there's pros and cons to everything. And, you know, there are risks to not being in the hospital, but there are risks to being in the hospital, probably a lot more, you know, in terms of the things that they might do that you don't, don't need.

I can say from experience working with a lot of patients with home birth. So, yes, some people need to go over the hospital. Most don't. I've never had any major issues with anybody who's on a home birth.

That certainly happens. But it happens in the hospital, too. And so maybe you can just talk to, you know, the interesting world that you're in now, which is not very common for an OB to work with midwives and and to be a part of home births and have a, you know, a better, better understanding of home birth than the average OB.

So you can just speak to that and talk to a parent who's maybe pregnant or considering another birth and what, what what they should be thinking about with home birth.

I appreciate the question. This is a very nuanced and complex question. We'll try to answer it in just a couple minutes as best I can. But people want to dig deeper.

And there's there's lots of resources for that. Like you probably, you know, I would well, that's one, but I was, there's lots of great books out there too.

And I was trained in the medical model, and I came out of residency thinking that I knew everything there was to know about obstetrics and in the medical system.

I did, but I knew nothing about normal. We don't watch normal. We don't see normal. We don't watch a woman labor. We are called to the room when the nurses want us to do something.

And so we're trained in the model that pregnancy is something where we have to do something and it gets ingrained in you. Again, you get indoctrinated into that thinking.

And I was lucky because when I came out, I was approached by some home birth midwives and asked to take their home birth transports. And I'm sure that I did it only for monetary gain reasons, and not because I thought home birth or midwifery was a good idea.

I didn't really know much about it, but that was a eye opening process, beginning of a process for me, where I began to see a whole nother way of looking at birth and realizing that this isn't the medicalised process that I've heard about, except in a small number of cases.

And I began to work with midwives, and I began to see that the midwifery model of care, which is treating pregnancy as a normal function of a woman's body and trusting nature and being aware.

And by the way, when you are an expert in normal as midwives are, you're very quick to recognize when something isn't normal. So, if everything is abnormal or if you're a hammer, everything's a nail.

So if you're an MFM or if you work in that model, every every woman is a potential problem. Whereas a midwife, every woman is a potential normal mom until she's not.

And the idea that you're safer in a hospital is only because the medical model tends to cause problems that wouldn't have otherwise occurred if you've been left alone at all.

But we don't know that because we're indoctrinated, whether it's through, Acog and propaganda or whether it's through watching television shows or movies or whatever else, how they just how they portray birth is this dramatic, scary thing.

And it is dramatic, but it's dramatic and in a glorifying, beautiful way. And we and we're not exposed to that. And since doctors really control the narrative, they they feel that way and they and they pass that and they project that onward to the, the women that they're taking care of.

So my experience was this when I first started, a collaborative practice with in-hospital midwives, we ended up taking care of all comers. The midwives take care, took care of all the normal stuff the pap smears, the annual checkups.

The well woman visits, the prenatal care, the, delivered the normal deliveries, and I would take care of the abnormal stuff, like somebody had cervical problems.

I would do the colposcopy and the biopsies. They needed surgery. I would do that. If they needed a breech delivery, I would do that or a cesarean section.

I would do that. And we ended up having a C-section rate of 7%. And I never heard I never could of believe that if you would, when I came out of residency ten years earlier, that that would be the case.

And in the same hospital, the larger group in the hospital was doing about 40% more deliveries a year than we were, had a C-section rate in the mid 20s.

Now, that sounds a little bit low for today, but this was we're talking about the, the mid 90s. So so we're talking about 20, 25 years ago. And, and the only difference was the model by which they were cared for.

And then eventually when I left the hospital world to do home birthing, I was actually a little nervous. The first few home births I did, even after I'd been backing midwives for 25 years.

But I realized that when you don't meddle with Mother Nature, things that go wrong go wrong rarely, and they go wrong slowly, and you can usually see them coming.

So it's extremely rare to have the sudden, rapid deterioration of the fetal status that you hear about in the hospital where they had to rush you down the hall.

And thank God you were in the hospital, because what would have happened if this had happened at home? Never realizing that these things generally don't happen at home.

When you don't starve a woman, immobilize a woman, hyper stimulate her uterus, numb her up with an epidural. And have her constantly interrupted in a fear based environment.

So I would just tell your listeners who are thinking about having a home birth to just consult with a midwife. You don't necessarily have to plan to go with her.

But even if you're planning to do a hospital birth, have some prenatal visits with a midwife because the whole model is different. A prenatal visit with a midwife is an hour long, just generally, and a prenatal visit with an OB is going to be, what, 5 to 8 minutes long.

If you're lucky? If you're lucky. So you can't possibly do all the preventative things. You can't also develop the relationship that makes you feel comfortable and safe and confident.

You can in in six minutes that you can in 60 minutes. You can't talk about nutrition. You can't talk about sleep. You can't talk about your relationships. You can't talk about, preventative care.

You can't talk about your dreams and desires and all those things in 6 or 7 minutes. You just can't. And I just that's night and day. Joel. The problem I feel sad for my colleagues that are stuck in the hamster wheel of the medical model.

And of course, most doctors these days are not even individual doctors anymore. They're they're employees of a larger system.

Home Birth Safety and Midwifery Care

They can't even make their own decisions. They don't decide how long they get to see somebody. They somebody else makes that decision. They don't decide what they can prescribe for them, what's whatever's on the formulary.

You know, if that hospital system doesn't, doesn't support feedback, they can't offer honest, informed consent. They have to skew their counseling to get the woman to do what the hospital system wants them to do.

This is not a this is not a system that's conducive to getting safer outcomes. And just by looking, you know, if you just look at the, where we are right now, we have, as you said, a rising abduction rate.

Why a rising C-section rate? Why, you know, a rising, chronic, condition, rising postpartum depression, rate. We have chronic diseases and illnesses in children, which it's multifactorial, of course, but we're not doing well.

And at some point, somebody should say, if we're not doing well, why are we doing more of what we're doing right? Maybe we're doing it wrong. And, you know, we're not prepared to have everyone give birth at home, even if suddenly 20% of women wanted to give birth.

I don't we don't have enough midwives to do that. Anyway. Right now, the home birth rate is about 1.4 or 1.5%. Nationally, the United States. And yet we have so many problems in obstetrics.

But it's not because 1.5% of women are giving birth at home. That just doesn't. That's not the math. The math is the problem is because of the way we're dealing with things in the hospital.

And so there needs to be a reckoning of why we are where we are and maybe relooking at how we did birth. How did we have a 5% C-section rate in 1970? How do we do that?

With the same rate of, you know, bad, you know, bad outcomes? The medical model only looks at one outcome. And that I lovingly say when I teach about this stuff with my Regents twin seminars, is, is they really care about having a live baby in the bassinet and how the baby gets in the bassinet, and what happens to that baby's future and that mother and that mother's future babies at that moment is not really their concern.

But midwives look at it differently. Midwives look at the woman as a whole person that she may have future desires and wants and needs. When doctors are deciding to induce somebody or do a C-section, or they're telling that breech birth shouldn't come out vaginally, that it should come out by cesarean section.

Now, whenever I see these women in consult, this is a really telling little anecdote. I ask them this question to the doctor who's recommending induction, or the doctor who's recommending you have a C-section.

Ever ask you if you want more children? And the answer is universally no, because how you deliver that first baby will affect all your other pregnancies.

And if you want a second or third or fourth or fifth or more, and you end up with a C-section for your first baby, for indications that might be rather questionable, you now maybe change that baby's health and outcome somewhat, but you've now put all your future babies at greater risk.

And that's never discussed. It's not. They don't look at it as a whole picture that, you know, medicine. I heard somebody on a different podcast recently describe the way we treat do things in medicine as whac-a-mole.

And I really love that analogy. We don't try to fix find the root cause of a problem or why are more women depressed or why are more women having C-sections?

We're just we're just going to treat this and we're going to treat this. I'm going to prescribe a pill for this. And then if there's a side effect from that pill, will describe another pill for this.

And the endocrinologist doesn't talk to the maternal fetal medicine specialist who doesn't talk to the ear, nose and throat doctor who doesn't talk to the OB.

It used to be when I first started in practice, when you did a consult on someone else's patient, you dictated a letter. You made a phone call, you called up that doctor and said, thank you so much for the referral.

You probably got a montblanc pen at Christmas from them, that sort of thing. Those those things are gone. But there was this all this communication. Now with electronic medical records, systems don't even talk to each other sometimes.

And, and it's, it's, it's all chopped up and it doesn't benefit the women that we're supposed to be caring for the. I couldn't agree more. I mean, that's even a big part of why I wrote the book in the first place, because, you know, there's so many parenting books out there, not a lot of them are done by physicians, and a lot of them go through, like, you know, the main questions that parents have, and I do a lot of that.

But I also talk about the health stuff because none of it matters if your kid's not healthy. And we're missing the bigger picture, which is that, you know, parents are unhealthy, kids are unhealthy, 50% of kids have a chronic disease.

You know, you're talking about the skywriting season, all these things. It all matters. It goes back to the beginning. And nobody is saying like, hey, we're obviously it's not.

Maybe we're doing something wrong. We are obviously doing something wrong. We are better at emergency care, we are better at infections. But there are things that we are much better at.

Like he used to die from pneumonia. You don't necessarily anymore, right? But we're terrible at chronic disease, were terrible at health in general. And we have to go backwards like, yes, we got good at one thing, but we're terrible at everything else.

We have to go back to the middle somewhere and we're not doing that. And unless we get rid of our, you know, let's we get rid of being beholden to pharmaceutical companies and insurance companies until we get outside of that model.

Like there's just no chance. Like you said, most doctors are employees, like the vast majority. The majority are employed by United at this point. And then, you know, the rest are mostly employed by Kaiser or whatever else.

And and during the pandemic, I think something like 25% of pediatrics is closed. You know, there's like almost no, no more independent doctors because it's it's basically impossible.

Like, I can speak to it. It's basically impossible unless you go outside the model and have some sort of other concierge type services, like you can't make enough money to stay open anymore.

It's not possible unless you get within the system. If you make if you, medical students and residents constantly being trained by high risk obese, then that's how they're going to think.

And you could change. You could change medicine to some degree tomorrow. If insurance companies decided to suddenly pay more for a vaginal delivery. And less versus Aryan delivery.

If they told the hospital instead of paying you two and a half times as much for cesarean delivery, we're going to pay you one and a half times as much as we are now for a vaginal delivery, and we're going to pay you only 10% of what we were paying you for a caesarean delivery.

You find that hospitals and systems would suddenly think that the back and breech and twins and and other things would be a good idea. Now I don't want to force doctors who don't know how to do those things, to do those things.

And I don't want systems to be dictating how we should be taking care of our patients. But that's the reality of the world we live in, is this is where the decisions are coming from.

And and as long as there's profit to be made in the way the system is, they don't really care that it's not working well for the individual client. They don't really care that the nurses and doctors aren't happy with.

Okay. And I, I mean, I couldn't agree with everything more that you're saying. And I know we can we can talk about this for hours and hours. Yes, we. Could.

And I think, you know, at least to me, you know, here like, really the moral, the story and the thing that I want to get across, which I'm really thankful that you did, was for for people to understand that there are so many options out there you don't necessarily have to go with within the medical system.

I don't think you should be scared of home birth. I don't think you should be scared to ask questions about induction C-section. You may need it. That's fine.

If you actually are one of those smaller percentage that do. But there are other options out there for someone who wants to be natural. And, you know, for people who are interested to be able to listen to your podcast or think similar or read books on that topic, I think it's really important to do, because we're both examples of people that came from the medical model, got outside of it to whatever degree, and then realize, hey, there's like a whole other world out there.

And yes, there are some scary things in that world, but mostly it's not. And mostly it's better. And these are things that you just need to be aware of.

If you and you shouldn't be scared, you should just learn about it. Yeah, well, midwives and home birth practitioners, like most human beings, want the best outcome possible for the women that they're taking in.

The families are taking care of, and they're not going to do things that are crazy because no midwife is going to get rich doing home birthing. So they do these things because of a love and a calling for what they're doing, and they want the best outcomes.

And if they thought that the hospital was the best chance for you to have the outcome that you wanted to, then you can believe that your midwife will want you to have that.

But I when I left the hospital system, I wasn't going to be doing home birthing. If if I thought it was dangerous, that would that would imply that I have nefarious motives, that midwives have nefarious motives.

Because we want the best outcome possible for the families that we're taking care of. So we wouldn't do home birthing if we thought it was unsafe. And that's and we do. We do.

I don't like to use the word cherry pick because I've expanded it because I'm doing I was doing diabetics and hypertensive. So we're properly controlled and healthy. Don't.

But we do cherry pick the clients. And certain women, as you said at the beginning, need to be born in the hospital. It's safer for them there. We believe now maybe, maybe we don't.

Maybe we just don't have the the cajones yet to be doing other things at home. But you can be sure for those people who are wondering about the safety of home birth, that your practitioner also is concerned about, that it would not do something to you or for you that they felt was unsafe.

So that's another way to be reassured that home birth people are, I mean, home birth practitioners are having your

best interest at heart by offering this, this service.

It's a matter of fact, they think it's a better model. I think it's a better model for most women, to avoid being in the hospital because the hospital isn't doing well.

And as you said earlier. Look at where we are. I mean, we just it isn't. I mean, maybe we should. We need to stop and reevaluate. We do. Right? We definitely do. Well.

And it has to come. And it has to come from the from the families, the women that are listening to this, the families that are listening to your think they need to be the ones that make the change.

They need to ask the doctor who says that you know, your fluid is lowest or your baby's big. Well, okay, so where's the data on that? Can you can you give me an alternative?

Can you talk about castor oil? As we talked, we started with the B at the beginning. Why do we have to go with, site attack and monitoring and then pitocin and not allowing me to eat, and, you know, you'd like me to have an epidural, early on.

Why? What's the what's the downside of those things? Start asking questions. Because right now, you know, and use that as a, as a, as a, a flag to determine whether or not you're in the right off it's or not.

If you start asking questions and your doctor sits down with you, looks you in the eye and answers them, then you're in the right office. But if they start tapping their foot or roll their eyes or or, demean your question, you know, you you have the power.

You're the consumer. You you can fire your doctor, you can seek out, a different model of care. Definitely. I mean, I've I've said that before. I mean, you know, many times that you are you're in control.

And there are so many other practitioners out there. And if you don't, if you don't ask the right questions, you don't ask questions, then you're not going to find the right doctor for you.

But you can you can fire your doctor and you can, you know, go to a place where they're going to at least respect your, your beliefs. If they're not, you know, if you're a holistic and they're not super holistic, but they're at least open to it, that's a much further, a much, a much better place than being somewhere that rolls her eyes and just like once they get rid of you because they're like, oh, that's the crazy we will patient that I have.

Yeah, I, I've been a big fan of yours ever since we had lunch that day. Years and years and years ago. Seems like forever ago. And, I appreciate what you're doing.

I'm very excited about your book coming out. We just. Because. Because look at I mean, I'm, I'm, not a fan of my profession, but I'm less a fan of your profession.

That's there right? I mean, I don't think that. I don't think that, pediatrics has done well. No, nothing. And preventative medicine has done well. And anyway, I don't know that I would say that, you know.

Well, and I think obstetrics actually has done a lot better, because if you look at the the rates of death from, from birth, they were, you know, much worse 100 years ago than they are now.

So I think overall, you can say that OB is doing is doing better in general in terms of birth and keeping babies alive. Maybe not in terms of respecting people's wishes, but I'm not sure that pediatrics and certainly not adults, you know, I mean, the life expectancy going down.

So yeah. And I would say that, yeah, we peaked I think we peaked in obstetrics maybe 40 or 50 years ago. And then we we can't stop meddling now. And, you know, that's the thing.

So you're right. The pendulum swings one way too far back, the other way too far. But but it needs to find a happy medium.

Changing the System and Final Advice

And I and I hope, I hope that by doing this and by your book and stuff like that, that we can begin to cause ripples to spread, that the people that we reach, what we call our fellow travelers on the podcast, they will talk to their family members and they will spread information and let people then make informed decisions.

But if you can't make, an informed decision, if you're only given skewed, information and the world is just too filled right now with skewed information and suppression, by the way of.

Other. Thoughts and ideas that are outside the mainstream narrative, one of the major ways that they, they deal with those sort of thing is to censor or ridicule anybody who has ideas that they feel are heretical.

Like somebody like you or me. You know, our mainstream organizations would not really be happy with us. But yet I would challenge any of them to, to have a debate about their model versus my model in front of a live audience, with a moderator just asking questions and having that conversation.

Problem is, is those things never happen. They just don't happen. Because that would be benefit, for the families that were caring for. And you'd think that they'd want that.

Yeah. You know, but they don't. They don't know. That's what it's a good place to end. I think it's, unfortunate, but it is what it is. And again, thank you so much for being here.

Can you tell people where to find do the your podcast or all those things? Okay. My website is birthing. Everything's birthing instincts. My website is birthing instincts.com.

And we have a website for the podcast called Birthing Instincts podcast.com and the podcast, it's called the Birthing Instincts Podcast. And on Instagram I'm at Birthing Instincts, so that's pretty much it.

I don't do Twitter. I don't do Facebook much anymore. You probably do Twitter now based on your your personality, you probably would do well. Yeah. You know, I just don't I don't want to I don't I don't want more stuff.

Fair enough. Yeah. I'm slowing down. I mean, I left California, I moved to southern Utah. I don't actively do births regularly anymore. I do them every now and then.

But mostly what I'm doing now is I'm teaching, I do consults, be a virtual consult. Like. Like we're talking. And then I go around the country, actually around the world.

And I teach breech and twin skills. I do a two day seminar and I do it, I my, I teach a different clinic course, but there's another group called Breech Without Borders that does great work.

And, for, health care workers, birth workers, doctors, obs, midwives, nurses, doulas, learning these skills can only make you a better, better at whatever your profession is.

Because knowing how to take care of a breech or twin, is important. Whether you're a doula and you can advise your clients that or whether you're a doctor and someone walks in with a baby's butt or a foot hanging out.

And if you don't know what to do, you're far more likely to end up with a problem. So this is where my passion lies right now. Bliss and and bliss wants me to write a book with her.

I'm going to talk to you about that off of off camera, because I just do get motivated. I wrote a book in 2004, and with the second edition in 2010 called Fearless Pregnancy.

But right now, it's just been a hard issue for me. As you said, I just want to slow down. I want to walk in in the trails. I want to be outside. I want to, live.

Like because I was on call every night for myself for nearly 40 years, and it takes its toll. Yeah. And a dedicated health care worker because it's hard, you know, the shift mentality that we have now.

I know I'm going off on another tangent here, but the shift mentality that you can edit this out but the shift mentality will leave it in. It's good stuff.

The shift mentality is better for a lifestyle. I mean, doctors right now have a better lifestyle, but it's not better for the women that you're taking care of.

It's not better for the, for the continuity of care. It's not better for enjoyment. I mean, it is, you know, I mean, you don't see the completion of your work when you work shifts. Medicine.

You can be with a woman all night long as a nurse, and she's ready to start pushing. And now you go home. And for me, the culmination of all my work was being at the, had a birth.

And if I missed a birth because I was on vacation or because I didn't get called in time or because there was traffic or whatever, it was always inside.

It was a bit sad because that's where the satisfaction comes from is. And that's why most people who choose to do obstetrics do obstetrics because they, they love it.

Right. So, yeah. The last thing I would, I would say is that for anybody that's listening that, that plans to have a hospital birth again, possibly seek out a midwife just for, just for some prenatal visits, you're likely to have a better outcome in your hospital birth if you see some visits with a midwife.

And of course, if you hire a doula. I love it. All right, well, I'm going to end there. And then we can we can keep chatting after. Thank you so much. You're welcome.