BACKGROUND ~ THE PROFESSION OF MIDWIFERY AND ITS RELATIONSHIP WITH ORGANIZED MEDICINE

"It not so much what you say as what you repeat over and over again" -- PBS News Hour, 6/28/2005, in relationship to the war in Iraq

CHAPTER ONE ~

Few people in the United States aware of the highly controversial nature of midwifery or the historical tension between the professions of medicine and midwifery. This controversy has nothing to do with the appropriate use of obstetrical medicine to treat the 30% of pregnant women who develop complications. We all acknowledge the critical contribution that obstetrics makes in reducing suffering and saving lives associated with the diseases and complications of reproduction. The question that concerns us is the routine or "prophylactic" use of these same medical interventions on the 70% of healthy women with *normal* pregnancies.

It is the latter category – healthy women with normal pregnancies -- that has been the traditional focus of midwifery care but which has, in the last century, been claimed by the obstetrical profession as their rightful patient base. In order to enforce the obstetrical preference for providing care to a healthy population, there was an extensive campaign in the early 1900s by organized medicine to eliminate midwives in the US. The various legal and legislative strategies used were largely successful, reducing the number of midwife attended births from 60% to 13% in a single decade (1910 to 1920). While a tiny remnant of the midwifery profession continues to practice in the United States, the historical prejudice of the medical profession and the legal and legislative barriers that such a bias generated over the previous century, makes it virtually impossible for midwives to take their appropriate place in the spectrum of health care services available to healthy women.

There continues to be much disagreement about the contemporary relationship between physicians and midwives. At the core of the question about the modern role of midwifery is yet another question -- what is the right relationship between "modern medicine" and "modern" childbearing? Has the obstetrical knowledge of the 20th century fundamentally changed the nature of childbirth (which is a natural biological act) the same way that medical science fundamentally changed the course of human illness, disease, deformity and accidental injury (all of which are abnormalities or forms of pathology)?

The short answer is that childbearing itself in healthy women is ***not*** fundamentally dangerous and does not routinely benefit from surgical skills. The scientific literature – research published in medical journals, textbooks, measures of maternal infant well-being such as birth registration and vital statistics data – all identify increased risk and unnecessary expense when drugs and surgery are compared to normal or 'spontaneous' birth in a healthy population. These scientific sources all make it clear that routine obstetrical interventions and normal birth conducted as a surgical procedure are statistically more dangerous for healthy women with normal pregnancies than the use of physiological principles, in conjunction with appropriate medical intervention when complications arise. Scientifically speaking, this is *not* a controversial finding. Reliable scientific

evidence is neither lacking nor incomplete, nor is this data the subject of great methodological disputes.

SURPRISE! MIDWIFERY IS THE EVIDENCE-BASED MODEL OF MATERNITY CARE . . .

For healthy women who are well fed, well housed, well educated and receive good prenatal care during pregnancy, the greatest realistic danger today is obstetrical over-treatment and the cascade of complications associated with the routine use of obstetrical interventions, such as induction of labor, narcotics, anesthesia, episiotomy, forceps, vacuum extraction or elective Cesarean surgery**.**

A recent example of just one of the problems associated with routine obstetrical interventions can be found in a June 1st, 2005 report entitled "Routine Episiotomy Offer Women No Benefits or Relief". An astounding 1.3 million episiotomies were performed in 2003. The report stated that: "the routine use of episiotomy for uncomplicated vaginal births *provides no maternal benefits*..." and that women without episiotomies were "more likely to have an intact perineum and to resume sexual intercourse earlier". [Ob.Gyn.News, Vol. 40, No.11]

For the last three decades the obstetrical profession has published a new scientific report on episiotomy every 4 or 5 years, each time identifying it as a *therapeutically unnecessary, painful and harmful procedure that failed to prevent future pelvic floor problems and thus should never be performed routinely*. This most recent of these studies noted that three-quarters of all episiotomies are not only unnecessary, but are being done without informed consent and often without even the permission of the mother. This amazingly important information was also posted on a federal government web site devoted to "evidence-based medicine" and reiterated the same conclusion – that routine use of episiotomy fails to achieve any of the protective benefits ascribed to it and is harmful to women. In spite of this and dozens of other studies with similar conclusions, about a million of episiotomies which serve no medical purpose continue be done year after year.

In August 2005 the Reuters new service reported that 1.2 million Cesarean were performed in **2003,** making it the number one hospital procedure, at a cost of 14.6 BILLION dollars**.** [Editor's note: for unexplained reasons, the original analysis did not include episiotomies as a 'procedure' of interest.] To put the economic cost of 1.2 million Cesareans in perspective, it should be noted that the 2005 federal energy bill signed on August 8th by President Bush was for only 14.**3** billion and the total estimated cost for the 1989 Loma Prieta earthquake in the Bay area was only 6 billion dollars (a mere 5 *months* worth of Cesarean surgeries). During the last 30 years, the rate of Cesarean intervention has gone from **one** out of **twenty** to approximately one out of ***three*** pregnancies (latest data was 29.1%), with *NO reduction* in the incidence of cerebral palsy or the rate of permanent, birth-related neurological damage.

This fact was brought to light in 2003 a report by a task force on cerebral palsy by the American College of Obstetricians (ACOG) and Gynecologists'. It was published after three years of intensively study, which included the effects of the routine use of electronic fetal monitoring (EFM). EFM is an expensive medical devise marketed as able to identify fetal distress early on, before it could produce neurological damage. Its use became the standard of care about 30 years ago. The theory was that continuous electronic monitoring of all laboring women, in conjunction

with the liberal use of Cesarean section at the first hint of problem as recorded by the EFM tracing, could and would permanently eliminate cerebral palsy and other forms of neurological damage. This gave rise to a frequently repeated obstetrical 'truism' - "when in doubt, cut it out". During the first decade of EFM use, the CS rate climbed from approximately 5 % to 25%.

However, the 2003 ACOG report concluded that neither routine use of EFM, nor the liberal use of C-section, either alone or in combination, had reduced the cerebral palsy rates at all during the preceding 30 years. Unfortunately a century of ever improving maternal health, which included a steady downward trend in maternal deaths, became flat during this 30 year period. Worse yet, there has been a slight rise in maternal mortality since the late 1990s, primarily a result of delayed and downstream complications of our sky-rocketing Cesarean surgery. When you combine the rate of episiotomies and C-sections for 2003, you get 2.5 million generally unnecessary operations, out of about 3.9 million annual births. Needless to say, the number of unnecessary childbirth surgeries will be even higher for 2004 and 2005.

Indisputable as this historical obstetrical interventions is, the medically interventive style of maternity care provided to healthy women in the United States for the last hundred years is not itself scientifically based. That is not to say that nothing within the art and science of obstetrics is scientific. Many wonderful, even life-saving treatments for various complications of pregnancy and childbirth are true scientific developments and can be proudly pointed to by the obstetrical profession. However, there is a slip 'twix cup and lip', a circumstance usually referred to as 'cognitive dissidence'. There is no credible scientific research to support the routine or 'prophylactic' use of obstetrical interventions such as automatic hospitalization of all laboring women or the routine use of EFM, labor accelerating drugs, episiotomy, etc, on healthy women with normal pregnancies. None the less the obstetrical profession has, for more than a hundred years, heavily promoted the idea that "more" of everything medical was better and that birth as a surgical procedure was best of all.

This is a particular problem because physicians are the natural spokespersons for the scientific discipline of medicine, a circumstance that places a societal burden of candor and accuracy on doctors by virtue of their advanced education. The obligation intrinsic in this special education creates a higher standard of conduct than mere recitation of personal preference or professional self-promotion. The very fact that physicians are the holder of a doctorate in the science of medicine (equivalent to a PhD) gives the public every good reason to believe that statements made by physicians about matters of health, safety and medical care are *unbiased, scientifically-based and factually correct.* This would include the duty to communicate *only scientifically valid* information in a public forum, unless such statements are identified as merely a personal opinion. However, little in the public discourse addresses, corrects or even acknowledges the century-long disconnect between the science and the practice of obstetrics as it is applied today to a healthy population.

THE CONUNDRUM BETWEEN MEDICAL SCIENCE AND OBSTETRICAL PRACTICE

Exploring the conundrum between medical science and obstetrical practice is what the rest of this document is about. Before beginning on that endeavor I want to state for the record that the following discussion, which includes the early politics of the obstetrical profession, is historical in nature. It is not mean to cast aspersions on individual obstetricians practicing today. I count

many hard working obstetricians among my closest friends and colleagues. I frequently *depend on their expertise* when midwifery clients develop problems that require obstetrical solutions. I am profoundly grateful for the modern science of obstetrics and apologize in advance for any offense that may be taken by any individual. I offer, in my defense, the possibility that we as a society might finally, after nearly 400 years of misdirection, correct a pervasive and troubling problem to the mutual benefit of all.

But unfortunately, an in-depth exploration of these historical events includes information that is unflattering to the political arm of the medical profession (usually referred to as "organized medicine"). While many would prefer that this information be left out, it would be impossible to really understand the modern-day topic of normal birth and the tensions between midwifery and medicine without these historical antecedents. Further more, I believe that blame placed on the obstetrical profession is wrongly placed. *It is we, the public, who have been asleep at the switch and not doing our job as citizens*. This is where both the problem *and it solutions* lie.

As citizens have been too quick to suspend disbelief in the face of unbelievable claims, such as the idea that is a reasonable, safe and cost-effective advancement of modern society to summarily replace the cost-effective physiological management of normal birth with expensive and surgically invasive procedures of unproven merit. For healthy women, the 'maternal choice' Cesarean is not, and never will be, safer or better than normal birth. And yes, induced labors scheduled elective Cesarean are obviously more profitable for hospitals (who can manage staffing needs more economically) and more convenient for physicians. But it does this by shifting added pain on to the mother and added economic cost on to other segments of society. This ultimately reduces the ability of the US to compete in a global economy on a level playing field, thus making high-tech obstetrics for healthy women an unsustainable and therefore unstable form of health care.

Physiological management of normal vaginal birth costs $2,000 to $4,000 (in an out of hospital setting such as client or maternity home) and about $9,000 to $12,000 for hospital care. Elective Cesarean section, which is frequently accompanied by admission of the baby to the intensive care nursery for at least a few hours, costs between $20,000 and $40,000. The figures for surgical delivery -- already 2 to 10 times greater than physiologic care -- *don't factor in any complications of that surgery*, either intra-operative, post-op, delayed or downstream. These can run into hundreds of thousands of dollars. Clearly, Cesarean surgery is the 'gift that keeps giving". And yes, this is good for business, assuming one's business is high-tech medical care.

However, if your business is General Motors, and you are paying $1500 for employee health insurance per car assembled in the US, while your competitors are only paying $300 per car assembled overseas (all countries in which physiological management is the standard of care for healthy women), the result is financially disastrous. For GM, it means closing down of 30 US assembly lines and eliminating the jobs of thousands and thousands of US auto workers. The unnatural and unfair proportion of health care resources devoted to a highly intervention and expensive obstetrical system for healthy women is a problem for every man, woman and child who lives and works in the US and must depend on affordable health care resources.

OVERLOAD OF POLITICAL ANXIETY

In the shadow of September 11th, 2001 the American public has, with good reason, become tired of the "crisis" of the month – hysteria over toxic dumps, bad schools, divorce, defective tires, dishonest accounting methods, corporate fraud and the on-going war in Iraq. More recently the list has been lengthened by the tsunami in Indonesia, hurricane Katrina in the US, and the horrible earthquake in Pakistan and India. The list of things that needs 'fixing' is endless and seems to be growing daily. We don't want to hear that there is *yet another* reason to worry about something that no one knows what to do about. Or worse yet, someone is proposing that we spend huge sums of money on research for a solution that will, no doubt, take decades to find and include some painful, far-fetched remedy or an expensive drug with horrible side-effects.

However, there is good news. Unlike wars, global warming, bio-terrorism and incurable diseases, we know what to do about this "problem". In regard to sustainable affordable maternity care, we have not been set adrift without a compass or a swift current that will carry us forward to a mutually beneficial solution. We already understand and know what to do about our currently dysfunctional maternity care system. The solution is no secret -- physiological management. There are lots of resources, including sound scientific evidence, textbooks and knowledgeable, experienced people (midwives and midwifery-friendly doctors) who can teach the principles and demonstrate skills of physiological management. This will reduce our Cesarean rate by more than 50% while making for happier mothers and healthier babies and freeing up an additional 10% of the health care budget to spend on people who are genuinely ill or injured. Physiological management as the foremost standard of care is cost-effective, safe, humane and attainable in our life time.

In the long run this is a win-win solution, as obstetricians will get to do what they are trained for -- focus care on those suffering from the diseases and dysfunctions of fertility and childbearing. And should a terrorism event (biological or otherwise) occur or a pandemic of bird flu overwhelm our hospitals with the injured or ill, both physicians and midwives will be able to provide safe, community-based maternity care without having to expose healthy women and babies to potentially lethal diseases or waste the precious medical resources of doctors and hospital beds on the care of a healthy population in the midst of a life/death national emergency.