Trish and Holly Talk Show on Midwifery

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and a Consumer Advocate from *Idaho Friends of Midwifery*



**Surprise**!  ~ Midwifery is

the evidence-based model of maternity care!

The best kept secret in the United States is that the midwifery model of care is the safest form of maternity care for healthy mothers with normal pregnancies and that midwives are the most appropriate and cost-effective attendants for normal birth. (1. Marsden Wagner & W.H.O *Practical Care for Normal BIrth.*) (2. Schlenzka �*Safe Alternatives in Childbirth*�) (4. Rosenblatt *� Interspeciality Differences in Obstetrics*�)

**Midwives have the best record for maternal-infant safety**, the lowest rates for medical interventions (such as induction of labor, episiotomy, forceps and CS), the least maternal complications (hemorrhage, infections, 4th degree laceratons, etc) and fewest admissions of babies to neonatal intensive care. (2. Schlenzka) Midwives also receive the best reviews from new mothers for satisfaction with their care and with the birth experience. (3. J. RookMidwifery and Childbirth in American) Midwifery care costs 1/3 to 2/3s less money than physicians. (4. Roger Rosenblatt)

**Midwives come in two basic flavors � nurse and non-nurse**. Professional midwives provide care in hospitals, free-standing birth centers and clients homes. The safety record for all three locations and both types of midwives is the same (3), with home-based birth care being a little safer for babies and having the smallest number of maternal interventions and complications. It also is the least costly. (2) Developed countries with the best infant outcomes and most cost-efficient maternity care systems use the midwifery model of care, with 70% of babies delivered by independent midwives. For example, Holland has one of the best perinatal outcomes of any country in the world, with **30%** of Dutch mothers receiving �domiciliary� or home-based midwifery care and another 30% delivered in hospitals by midwives.

Records of the successful traditions of midwifery go back many thousands of years, to the times of the ancient Egyptians (3500BC) and the Old Testament and yet the Eternal Verities of normal childbirth are as fresh and true today. The success of midwifery is based in **a universal respect for an undisturbed physiological process.** This includes a deep trust in the healthy woman�s ability to give labor and give birth spontaneously when the physical, psychological and gravitational needs of normal biology are met. The first priority for midwives (and physicians using midwifery principles) is **not to disturb the normal process**.

An undisturbed labor in a healthy woman that is permitted to be �normal� (for example, no artificial time constraints, etc) and managed physiologically will usually progress on to a spontaneous birth. The mother-to-be will neither need nor benefit from being put to bed, having continuous electronic fetal monitoring, IV fluids or artificial hormones to stimulation labor (Pitocin) or narcotics and epidural anesthesia. An episiotomy to expand the birth canal is not helpful nor will forceps, vacuum extraction or a Cesarean section be necessary. Instead of medical and surgical procedures, **midwives rely on �patience with nature�**, **hands-on social support and encourage upright positions** to help the mother�s labor advance, reducing the likelihood that potentially dangerous interventions will be needed.

When the labor and birth are normal, the baby is generally healthy and will not need any kind of expensive, anxiety-provoking neonatal intensive care. After a spontaneous vaginal birth the mother�s breastfeeding efforts are more likely to successful and she is much less likely to suffer from postpartum depression while enjoying enhanced self-esteem. (5. Predictors, prodromes and incidence of postpartum depression. Chaudron LH, J Psychosom Obstet Gynaecol 2001)



**~ Pregnancy makes a mother as well as a baby ~**

Active participation during childbirth is an important developmental milestone and a natural preparation for parenting. Being a parent includes a host of �challenging� situations in which mothers and fathers need to go beyond their comfort zones, to meet challenging situations with persistence and press on in the face of anxiety and discomfort. They may have a colicky or sick baby, an injured child or one with a learning disability or problems in school. They may be called on to provide long-term care for a handicapped child or elderly adult. Most adults face marriage or job difficulties at sometime in their lives or suffer the loss of a loved one and other difficult circumstances like a house fire or flood.

The ability to tolerate mild to moderate anxiety over the course of several hours without being forced to resort to instantaneous fixes (such as prescription or illicit drugs use) is a big contribution to personal mental health. **Labor and birth offer an opportunity for parents to learn how to work together to cope with a stressful event**. Being able to �raise to the occasion� of a physical and mental challenge can leave the couple feeling more confident and competent in their ability to handle whatever life sends their way, including the responsibility of caring for a newborn. When we eagerly administer narcotics to laboring women and routinely administer epidural anesthesia (95% rate in many hospitals), we not only increase the risk of narcotic addiction for the baby later in its life but also deprived parents of significant developmental experiences that will be important long after the memory of labor pains has faded.

~ Right Relationship with Technology ~ Midwives use the best, leave the rest

Modern-day midwives are not luddites, nor anti-technology, anti-doctor or anti-hospital. Choosing midwifery care does not mean that women cannot benefit from ultrasounds during pregnancy, Pitocin to speed up a slow labor or pain medication and epidural anesthesia if desired or required. It only means that women do not have to have them because there are no other effective methods to help them make progress or manage pain. Hospital midwives are authorized to utilize the same basic drugs and equipment as do physicians and can order epidural anesthesia if requested by their labor patients. Community-based midwives are trained and equipped at a level equivalent to emergency procedures, drugs and equipment found in community hospitals  -- IV fluids, oxygen, doptone, anti-hemorrhage drugs and equipment for neonatal resuscitation. Many midwives also have portable electronic fetal monitoring systems and pulse oximetry that can be used in domiciliary setting.

If midwifery is so safe, successful and cost-effective, why isn�t it the norm?

The reason that midwifery has not become the standard for normal birth in the US has nothing to do with midwives. It is the result of a vitriolic propaganda campaign against midwives begin in the early 1900s when obstetrics was first being developed by an all-male medical profession. At the time women did not yet have the right to vote. Historically there was **an irrational and scientifically-unsound exuberance by doctors** to replace the woman-centered practices of midwifery with operative obstetrics, substituting instead the interventionist care of doctors and nurses. This remains the goal of organized medicine today, which sponsors campaign to eliminate all �non-physician� practitioners.

Historical Backdrop for this Modern-day Dilemma

In the early years of the 20th century it seemed only logical to �medical men� that if informally trained *women* (i.e. midwives) could do a decent job of delivering babies without benefit of drugs and surgery then male doctors, trained in prestigious medical schools and with all the supposed benefits of surgical interventions at their fingertips, could do a vastly superior job. This was never true but it was an attractive idea to doctors and an easy sell to the lay public.

The high rate of maternal-infant mortality at the turn of the century was not related to midwifery care but primarily was caused by social-economic conditions such as poverty, malnutrition, poor sanitation, lack of adequate public health policies or access to medical care when complications arose. None-the-less, organized medicine blamed all childbirth-related ills on midwifery and launched an official **campaign to eliminate the independent practice of midwives** **as quickly as possible**. Publicly they promoted the self-serving notion that it was unfair to poor women to deny them benefits of the obstetrical �improvements� of the day � chloroform and ether anesthesia, episiotomy and forceps.

Within ten years (1910 to 1920) the rate of midwife-attended births dropped from 60% to 13% and down to zero in some places. In many locations non-nurse midwifery was outlawed all together and remains illegal to this day. (4. DeVitt *Elimination of the Midwife 1900-1930*). This was especially advantageous to medical schools as it permitted doctors to use thousands of healthy mothers and normal births formally delivered by midwives as �teaching material� for medical students. Unfortunately, this resulted in the routine use of anesthesia and operative delivery, which was dangerous for both mothers and babies.

Instead of treating childbirth as a normal body process, physicians related to the care of healthy childbearing women as *an opportunity to develop their skills in operative obstetrics* by routinely using chloroform, episiotomy, forceps and manual removal of the placenta at every normal birth. Anesthetic deaths, hemorrhage, infection, brain injury to newborns and long-term gynecology complications for mothers followed in the wake of these ill-conceived ideas. Unfortunately it was equally easy to conclude that these bad outcomes indicated that childbirth itself was intrinsically pathological when in fact it was the application of emergency interventions to normal circumstances that was so predictably dangerous. None-the-less, this false association between normal birth and medical emergencies fueled the propaganda campaign to further medicalize childbirth and foster a climate of fear about normal birth.

As a result of the switch from midwives to physician attendants, maternal death rates rose by 15% each year for several decades and the birth injury rate by 44%, as doctors replaced the midwife�s  �patience with nature� by �artificial, forcible and mechanical means�. In a speech in 1932 praising the newly-formed Kentucky Frontier Nurse Midwifery Service, a physician-statistician for the Metropolitan Life Insurance Company calculated that the absence of professional midwifery care in the US resulted in **10,000 preventable maternal deaths each year** and at total of 60,000 avoidable stillbirths and neonatal deaths. Despite identifying 70,000 avoidable maternal-infant deaths annually and many more serious birth injuries (cerebral palsy, mental retardation), the medical profession was unwavering in its continuing efforts to suppress and eventually abolish independent midwifery.

The cost of eliminating �Right Use of Gravity� and �Patience with Nature�

The price paid for systematically dispensing with patience, ignoring gravity and disparaging social support for laboring women was enormous and far-reaching but invisible at the time. The result of the historical campaign against midwifery was an **uncritical acceptance** **by the public and the medical profession** of a **totally unscientific premise** � that normal childbirth in healthy women is intrinsically pathological and dangerous, that right use of gravity has nothing to contribute to normal birth and that routine obstetrical care for healthy women makes birth better and safer than would occur under the care of experienced midwives. Historically, the **care of skilled midwives was always safer than that of physicians**, as the use of medical and surgical interventions by doctors predictably increased the number and seriousness of complications for both mother and baby.

This historical effort to eliminate midwifery has contaminated our cultural view of childbearing for the last 100 years and left us with an **exaggerated, pathological fear** of normal childbirth all out of proportion to the real but rare dangers. For many generations of mothers-to-be, this contagious fear became a severely debilitating psychological problem that actually caused medical complications (and necessitated use of potentially dangerous interventions). This does indeed make childbirth more dangerous and makes for a self-fulfilling prophecy that reiterated organized medicine�s �party line� ~ that every baby needs to be delivered by a physician and surgeon because normal childbearing is so dangerous and unpredictable.

In our own era this history of chronic fear translates into a 95% physician-attended hospital birth rate, with Pitocin accelerated labors and epidural anesthesia employed over 80% of the time, an episiotomy rate of 56%, an operative delivery rate -- forceps, vacuum extraction and CS � of more than 1/3 of all births. The US spends more money on maternity care than any other country in the world, and yet we are 22nd (third from the bottom) in perinatal outcomes, 14th in maternal outcomes and have the 2nd highest CS rate in the developed world. Cesarean section is the most frequently performed major operation in the United States with approximately 900,000 every year (a CS every 39 seconds). Episiotomy is the most frequently performed �minor� surgery -- **over 2 million each year**.

It seems that American obstetricians have yet to discovery the laws of gravity and proudly flaunt their membership in the **Obstetrical Division of the Flat Earth Society**. This is often accomplished by keeping the mother in bed, giving her labor-retarding narcotics and pelvic-floor numbing anesthesia, requiring her to push lying on her back or sitting at a 45 degree angle on her sacrum, while urging her in prolonged breath-holding and maximally hard, prolonged expulsive efforts � all non-physiological tactics amply identified as unnecessary, ineffective and even detrimental. **Weight bearing on the maternal sacrum closes down the pelvic outlet** by one quarter to one third while requiring the baby to be pushed uphill at a 60 degree angle against gravity through a partially closed door, a feat many first-time mothers cannot manage without damage to either themselves or their babies, irrespective of the use (or not) of episiotomy. These iatragenically-created problems are then perceived by doctors to be proof of a fatal design flaw in normal reproductive biology that can only be overcome by eliminating vaginal birth all together!

Midwifery & the Cone of Media Silence �

**In spite of a high success rate for midwives in promoting safe and successful vaginal birth**, there is a media lock-out of news and information on normal childbirth and midwifery. Rarely if ever does the media provide an unbiased opportunity for the discussion of appropriate, cost-effective maternity care and the �right use� of obstetrical services. The economic conflict of interest between organized medicine and midwifery is never acknowledged. This media dead zone is only pierced by inaccurate information that appears to be designed to carry out the agendas of organized medicine.

Recently the problems created by a century-long propaganda campaign have taken on a new urgency. The �new and improved� campaign of organized medicine is **to make normal childbirth itself obsolete**, to be replaced instead by �daylight obstetrics� and electively scheduled cesarean surgeries, promoted now by obstetricians as the preferred and �safer� choice, the ultimate in �women�s lib�.

This romance with prophylactic cesarean is based on the **erroneous** **idea** that damage to the mother�s pelvic floor is an unavoidable �collateral damage� of vaginal birth. The obstetrical profession has never acknowledged the value or even the existence of non-medical (i.e., physiological) management techniques, which historically have proven successful at preventing prolonged or ineffective pushing (thus reducing the risk of maternal exhaustion & fetal distress) and at preventing or reducing perineal trauma during childbirth (and subsequent pelvic floor damage and gynecological problems).

This sad state of affairs is intimately tied to medical profession�s historical preference for episiotomy (and a host of other interventions), coupled with their failure to learn, teach or utilize physiologically effective (midwifery-based) techniques for managing expulsive labor. It also reflects the disturbing fact that episiotomy � always promoted by obstetrical professors as �protective� against pelvic floor damage � is ineffective for that purpose, while contributing heavily to severe 3 and 4th degree lacerations that do indeed damage the integrity of the pelvic floor. Like the relationship between routine use of continuous electronic fetal monitoring, fetal distress and a raising rate of CS, episiotomy is another obstetrical intervention that tends to cause or acerbate the very condition it was suppose to prevent.

Midwives and Normal Physiology are out,

Surgeons and Medically-Unnecessary Cesareans are in!

An astonishing notion is now being promoted by the obstetrical community -- that vaginal birth is so damaging to mothers, so dangerous to babies, so �old-fashioned� and backwards that only its total elimination will do. This is one of the most pernicious developments in the history the obstetrics. (see [www.collegeofmidwives.org/safety\_issues01/rosenbl1.htm](http://www.collegeofmidwives.org/safety_issues01/rosenbl1.htm)) It would change the focus of a physician�s care from attending to the needs of the mother during spontaneous vaginal delivery to determining when fetal lung maturity was achieved so that the CS could be scheduled before the mother went into spontaneous labor by mistake and (gasp!) gave birth naturally!

An example of how far the agenda of the medical community is from the genuine interests of childbearing women is offered in an article published in the New England Journal Medicine (May 1985) entitled **Prophylactic Cesarean Section at Term*?***  The two physician authors (George and Jennie Feldman) make a case for Cesarean on demand and seriously promote the idea that a 100% scheduled or �prophylactic� cesarean surgery become the norm for all women. This is described as �saving� babies with only a �little excess� or �extra maternal mortality� and opin that the �**low cost of excess maternal mortality** **may be a price worth paying**�. Here is an excerpt:

p. 1266 �.the **number of extra women dying** as a result of a complete shift to prophylactic cesarean section at term would be 5.3 per 100,000�.  This may be the proper moment to recall that the number of fetuses expected to suffer a disaster after reaching lung maturity is between 1 in 50 to 1 in 500. � if it could save even a fraction of the babies at risk, these calculations would seem to raise the possibility that a shift toward prophylactic cesarean section at term might save a substantial number of potentially healthy infants at a relatively **low cost of excess maternal mortality**.

�We probably would not vary our procedures if the cost of saving the baby�s life were **the loss of the mother**�s. But what if it were **a question of 2 babies saved per mother lost**, or 5 or 10 or (as our calculations roughly suggest) as many as 36 or 360? �.  Is there some ratio of fetal gain to maternal loss that would unequivocally justify a wider application of this procedure?�  p

�p. 1267�.is it tenable for us to continue to fail to inform patients explicitly of the very real risks associated with **the passive anticipation of vaginal delivery** after fetal lung maturity has been reached?  If a patient considers the procedure and decides against it, must she then be required to sign a consent form for the attempted vaginal delivery?�

In keeping with these extreme sentiments, the current president of the American College of Obstetricians and Gynecologists began publicly promoting medically unnecessary cesareans in June of 2000 as the ultimate choice in reproductive �freedom�. The mere possibility of pelvic floor damage subsequent to vaginal birth has become the rationale for promoting the idea of cesarean on demand as �safer�, �better�, �maybe should even be routine� and **simply** **a matter of a �woman�s right to choose**�.

On *Good Morning America* (6/20/00*)*, Dr. Harer answered Diane Sawyer�s question on relative safety between normal birth and elective CS by saying: �For the mother, the immediate risks for a cesarean section are a little higher, but the longer term risks of pelvic dysfunction, urinary incontinence, pelvic dysfunction -- those risks are higher for vaginal birth and over the long time I think that the risks balance out � there really is no big difference.�   Unfortunately, surgical complications (infections, blood transfusions, emergency hysterectomy) and maternal deaths during and after delivery Cesareans are 2 to 5 times that of normal vaginal birth. Mothers and babies are also at increased risk for serious, sometimes fatal, complications in future pregnancies (such as placenta previa or percreta) as a result of a previous Cesarean. Apparently this is seen by Dr. Harer as �minor� price to pay.

In July of this year (2001), the Associated Press and NPR heavily promoted a *New England Journal of Medicine* article on inducing labor in Vaginal Birth After Cesarean women. The conclusion as promoted by the national media coverage would lead us to believe that we should return to the 1930s idea of �once a cesarean, always a cesarean�. No one mentioned that a repeat cesarean is of equal or greater risk to the mother than the complications of VBAC. An alternate (but unexplored) conclusion was that we should **stop the dangerous practice of inducing previous cesarean mothers**. There was also no mention that elective inductions significantly increase the rate of first-time Cesareans.

Informed consumers long for a return to the �..passive anticipation of vaginal birth�. My question is quite different from Doctors Feldman and Harer, as I want to know if it is tenable for obstetricians to continuously fail to inform healthy women of the high risk associated with �obstetrics as usual�, with its high rate of labor induction and cesarean surgery and rare or non-existent use of effective and low-cost methods to reduce these problems, such as **staffing hospitals with nurse-midwives**. Unlike physician care providers, hospital nurse midwives enjoy a low rate of interventions (especially induction, episiotomy and Cesareans) while having superior perinatal outcomes and achieving all this for a third less money? ( Midwives Deliver Healthy Babies With Fewer Interventions NY Times,  Dr. Roger Rosenblatt, MD)

# **Safe Maternity Practice**

**~ Reform & Rehabilitation**

With no effective public oversight, our maternity care system has become a cornucopia of �unsafe maternity practices�. For the last 100 years there has been an **inherent conflict of between the professional interests of obstetricians and those of childbearing women** that has never been publicly acknowledged or addressed. Nor has anyone pointed out the fundamental error of assuming all obstetrical practices are scientifically based. Obstetricians have **never been held accountable for scientifically establishing the safety of the interventions they introduced into normal maternity care** **over the last century.** Here in the first decade of the 21st century, doctors are still not held responsible for applying the elemental body of knowledge -- physiological management & right use of gravity -- that has successfully underpinned spontaneous vaginal birth all over the world throughout history. This is as elemental to �safe maternity practices� as washing one�s hands is to safe medical practice.

Nor are obstetricians being required to obtained informed consent before using unproven (i.e., experimental) practices, many of which are potentially injurious, costly and clearly less successful at facilitating spontaneous birth than physiological management. In every other medical discipline, doctors and drug companies are required to follow FDA experimental protocols, provide truthful information to patients and obtain �informed consent� before using new or unproven methods. Why don�t these common-sense rules apply to the obstetrical use of unphysiological techniques (anti-gravitational positions for pushing, weight bearing on the sacrum) and experimental surgical techniques such single layer suturing of Cesarean incisions (causes a 3-fold increase in uterine ruptures).

The first major area of concern is the absence of the �right stuff� -- a failure of contemporary maternity care to utilize the midwifery model of care as the standard for normal birth, both in and out of hospital. Physiological management can be used anywhere by anyone but it this is not happening in medical institutions. **Midwifery principles and practices are** **conspicuous only by their absence**. Approximately 70% of childbearing women are healthy and have normal pregnancies and yet 95% of these healthy mothers are simultaneously denied the cesarean-reducing benefits of midwifery management (which can be employed by physicians as well as midwives) while being subjected to cesarean-increasing, interventiontist obstetrics. (2. Schlenzka) This is to say, **labor was �managed� by a busy L&D nurse who was out of the labor room 79% of the time** (�Supportive Care by Maternity Nurse: A Work Sampling in an Intrapartum Unit� 1996 Birth, 23:1; 1-6) and a physician who was not even present in hospital until the last few minutes before the birth or who only came in to perform the Cesarean after things began to go awry. (Dr Rubsamen, MD, LL.B *The Obstetrician�s Professional Liability -- Awareness and Prevention, 1993)*

# **The Absent Obstetrician Syndrome**

**~ an Accident Waiting to Happen**

The second category of concern is the legal consequence of the absent-obstetrician syndrome, which shows up as a vastly increased rate of malpractice claims and litigation, making the profession of obstetrics disproportionately risky and expensive (and way more defensive!) than it need be. An expert in the field of obstetrical liability studied a sample set of 63 obstetrical malpractice cases involving permanent brain damage and subsequent litigation. In a book entitled *The Obstetrician�s Professional Liability -- Awareness and Prevention* the author (a physician-lawyer) presents these cases as "instructive" and "cautionary tales", designed to acquaint readers with the malpractice traps that have made **obstetrics a "loss leader" for liability carriers throughout the US**.

The **absence** of an awake, decision-making, practitioner who actually remains in the presence of the mother through out labor played a central role in approximately 2/3s of these malpractice cases, particularly those that necessitated telephone conversations between nurses at the hospital and the doctor who was not. This gave rise to misunderstandings or miscommunication between those present at the bedside (who don�t have the training or authority to intercede on their own) and those absent from the scene (doctors with training and responsibility but not present to use them). **Continuity of care is also missing** and its lack causes other problems, as the doctor doesn�t actually know what has and has not been tried or exactly how long a situation has persisted. It is like trying to steer a car over the phone.

An �absent obstetrician�, combined with an unexpected medical situation (the basic reason families choose hospital care!), results in an **avoidable** **bad outcome** for mother or baby far too often, predictably followed by a malpractice lawsuit against the doctors and the hospital. Litigation occurs in regard to what was said by whom, whether or not a call was made by the nurse to the doctor or the exact time of the phone call. The nurse and the obstetrician each blame the other for the unfortunate outcome. It is the usual malpractice nightmare, but unique in this respect -- it is the one malpractice risk that is the **most predictable and most preventable**. �As a result of a nail, the rider was lost�. One of the reasons that approximately 10% of obstetricians get sued each and every year is because doctors do not �do� labor. The �absent obstetrician� is a preventable accident waiting to happen and when it does, the rest of us have to pay the bills for artificially inflated healthcare cost to cover huge malpractice loses.

**This** **problem would** **disappear overnight** if labor and delivery units were staffed by professional midwives who were continually present during active labor and who routinely delivered all healthy women with normal pregnancies and spontaneously progressive normal labors (unless the mother requested to be attended by a physician). The economic advantage of this safer system are astounding.

Episiotomy � The American Version of Female Circumcision

Last but not least of the urgently needed changes concerns the right use, misuse and abuse episiotomy. Surgical incisions into the mother�s perineium are medically useful **only about 6 %** of the time (the rate for midwives in Holland). The �right use� of episiotomy is for maternal exhaustion or when a baby is in trouble and needs to be born quickly. Both of these situations are rare (1-2%) and yet we have a **current rate in the US of 56%**. With an annual birth rate of about 4,000,000, this would mean 50% or about 2 million medically-unnecessary �injurious procedures� are performed each year by uninformed doctors. Every decade 20 million unnecessary and painful surgeries are done without informed consent. An excellent study, exposing the routine misuse and abuse of episiotomy, was published by two researchers (Thacker and Banta) in 1983, and yet there have been 36 million additional unnecessary episiotomy since that time. Over the last half-century, a staggering **one billion unnecessary episiotomies were preformed** � sometimes with fatal consequences -- for no good social or medical purpose. The desired change in physician behavior has two distinct parts � doctors must stop doing the wrong thing (episiotomy) and must **start doing the right thing** � physiological management of 2nd stage labor as employed world wide with excellent results. Simply not doing episiotomies is *not enough*, when the **wrong use of gravity** results in preventable perineal trauma caused by the extreme efforts of trying to push the baby uphill against a closed door or if **fear of pelvic floor damage** results in increased use of medically-unnecessary Cesarean surgery.

Why can we do to Improve Maternity Care?

The solution to the modern-day dilemmas of maternity care does ***not*** lie in blaming individual doctors. Their actions are true to what they were taught in medical schools. Unfortunately, **much of what doctors were taught about normal birth was wrong** and information on many important aspects of physiological childbearing was completely missing. Most doctors never see the �normal management� of labor or an unmedicalized spontaneous birth. These problems are systemic, not individual. The medical system needs rehabilitation at several levels � educational as well as clinical, private as well as public, personal as well as professional. Instead of blame we need a substantial change in the national dialogue about our maternity care policies**. The midwifery model of care needs to be the legal standard** for normal pregnancy and birth in healthy women.

With Midwives on Staff, Hospitals are a great place to have a baby

Embracing the Midwifery Model of Care would mean reintroducing the ��passive anticipation of vaginal birth� as the ideal to be achieved by both doctors and midwives. This would require **hospital labor and delivery units to be routinely staffed by professional midwives** and normal births attended by those midwives. It would guarantee that healthy mothers would receive continuing, one-on-one midwifery care, with a Cesarean rate of say, 6% (or less!). Use of episiotomy would be rare and babies would enjoy a low perinatal mortality rate equal to or better than that of Japan and the Netherlands.

It would expand the use of physiological management to all physicians who provided care during normal labor, including physiological (or �delayed�) cord clamping so that babies are not deprived of this rich supply of their own stem cells. It would return the use of episiotomy and operative delivery to circumstances of genuine medical need. For example, it should be malpractice for an unanesthetized women to have forceps or a vacuum extractor used on her without first been encouraged to push in an upright position or squat on the side of the bed during contractions. �Evidence-based� obstetrics would be legally mandated, as would informed-consent for unproven procedures or off-label use of drugs.

 Changing the Cultural Context

for Home-Based Birth Services

Rehabilitation of our maternity care system would also mean that community-based or �domiciliary� midwifery would be accepted and respected as another one of several safe options for birth care, just as it is everywhere else in the world. Mothers should never be forced to choose between �extremes�, that is, an unnecessarily risky or unattended labor at home ***or*** an unwelcome, unnecessary medical intervention in a hospital. Recognition that all categories of professional care providers and all locations for birth are equally safe would permit us to acknowledge the obvious -- that **childbearing women have a constitutional right** **to choose** **the manner and circumstance of their birth** based on their own preferences (including the choice of an experienced homebirth midwife) and still continue to have appropriate access to medical services or hospitalization, offered without prejudice or recrimination.

 Acceptance of direct-entry midwifery as a profession in its own right is necessary so that midwifery training schools and certification can be established and so home-based birth services can be compensated by health insurance companies and Medicaid. Formal training and either national certification or state licensing makes egalitarian and cooperative relationships between physicians and midwives possible. Complimentary professional relationships are needed so that appropriate access to physician and medical care and hospital services is easily available to clients of community midwives. This is protective of the safety of mothers and babies who develop complications or who wish to be electively hospitalized for a �relocated home birth� if a minor problem arises during labor.

 As Mother and Midwife, I have a Dream�. 

I pray to live long enough to see a national maternity care policy in which hospital labor and delivery units are routinely staffed by professional midwives. In this �brave new world� healthy mothers with normal pregnancies normally receive one-on-one care from a professional midwife and are never medicalized until all the known techniques of good midwifery care have been tried and found wanting. I pray to see the day when mothers and community midwives enjoy the advantages of home-based maternity care without having to endure the vitriolic insults of local doctors or be threatened with criminal prosecution.

As Martin Luther King said so much more eloquently than I, �I have a Dream�. It is a big dream and I have had it for a long time. Fair and effective news coverage would do much to elevate the professional discourse between obstetrics and midwifery. A public education campaign to offset the historical propaganda campaign of organized medicine would be a great place to interject correction action and would at the very least head us in the right direction.

A philosophy of reconciliation is perhaps best described in a little-known story told about Eleanor Roosevelt during the years that she was mother of young children as well as First Lady. When asked what she put first in her life, her husband (then President of the United States) or their children, she replied that "together with my husband, we put the children first." I have always appreciated that story as portraying the ideal relationship between physicians and midwives -- that together we put the practical well-being of mothers and babies first.

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650 / 328-8491  goodnews@best.com    College of Midwives @ [www.collegeofmidwives.org](http://www.collegeofmidwives.org/)

Safety Issues @  [www.collegeofmidwives.org/safety\_issues01/safetyIndex01.htm](http://www.collegeofmidwives.org/safety_issues01/safetyIndex01.htm)

Cesarean specific citations ~ [www.collegeofmidwives.org/news01/nejm01a\_vbac\_study\_npr.htm](http://www.collegeofmidwives.org/news01/nejm01a_vbac_study_npr.htm)

Hx of Medical and Midwifery Politics: <http://www.collegeofmidwives.org/safety_issues01/rosenbl1.htm>

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