September 11, 2004

Recent Correspondence with Medical Board Members

Dr Fantozzi and/or the members of the Division of Licensing

**1)** [**Letter to Dr Fantozzi**](#gjdgxs) **included with a hard copy of the California College of Midwives'  Standards**

**2)** [**Internet access to the Standards**](http://docs.google.com/Standards_2004/Standards%20IndexPDF_Aug2004.htm) **of Practice, Protocols, Policies and Minimum Practice Requirements**

**3)** [**September 11, 2004 Letter to all Members / DOL**](#1fob9te)

**4)** [**Critique of the**](#30j0zll) **"Outcome of Planned Home Birth in Washington State"**

# **Dr Fantozzi, Chair, Midwifery Committee**

**Medical Board of California / DOL**

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September 2, 2004

**Re: Enclosed Standards of Practice for California LMs**

Dear Doctor Fantozzi,

I look forward to seeing you on October 8th  and share your goal of efficiently dispatching with this nagging issue. Unfortunately, I expect that both of us will be disappointed.

Enclosed is an updated, pared-down, reorganized and reformatted version of our standards of practice, guidelines, protocols, polices and minimum practice requirements for California licensed midwives. This version was developed specifically to reflect the educational background of California LMs and scope of practice as reflected in the LMPA. All technical bulletins have been moved to a second volume, so that, unlike the original CCM �Blue Book�, this new version can be read cover to cover in about 45 minutes. If I do say so myself, its practically poetic.

In order to conform to the legislative intention of the LMPA and its amendments, including the specific legal mandate of SB 1950 to �adopt regulations defining the appropriate standards of practice � for midwifery�, it is the considered opinion of legal, consumer and professional groups that the �standard of practice� for midwives must conform to the universal standards for community-based midwifery in order to be functionally �appropriate� and that an �appropriate� standard for  *California* midwives would arise from the California community of midwives.

It should be noted that  *standards* of practice are not the same as *scope* of practice. SB 1950 only authorizes the MBC to adopt standards via the regulatory process. It does not direct or authorize the Board to make changes in scope of practice as reflected in the legislative history of regulated midwifery in California, the current LMPA and in OAL Judge Roman�s ruling in the Osborn case. The Standards, Protocols, Guidelines and Minimum Practice Requirements as presented to you in this notebook fulfill the identified legal and legislative criteria noted above.

I would also like to draw your attention to �Section Two � Administrative Obligations� and its requirements for each individual midwife to report the number and characteristics of the client population served by her each year as well as all emergency transports and any significant morbidity or mortality and to submit m & m cases to a peer review process. Accurate and on-going statistics of this type and a formalized structure for oversight is the major missing piece in this controversy, at least from the perspective of the Legislature, the MBC, the midwives and the consumer/public.

The issue of unattainable and thus irrelevant physician supervision, in which the real point from A\_COG�s perspective was control, has eclipsed the true function of your regulatory agency and that is on-going oversight and remedial action. Organized medicine, as the writer of the language in the LMPA, chose physician supervision instead of agency oversight, so that it, *instead of the Board*, would have control over the practice of midwifery. This would permit them to eliminate homebirth, as well as using LM licensure for its own purposes such as an additional source for �physician extenders�. True to A\_COG�s1993 policy choice, they now prefer to promote Henny-Penny, �the sky is falling� politics and to hang their whole case against domiciliary midwifery on a single piece of really reprehensible junk science, in particular the Washington State Planned Home Birth study (which is none of the things its title implies!), instead of promoting common-sense measures such as good data permitting  objective conclusions and appropriate corrective remedies when and where indicated.

Birth outcome data such as reflected in these Administrative Obligations should be, but is not, available thru the State Office of Vital Records (OVR) statistical data bank. The CMA has always fought bitterly on this issue, saying on one occasion that for midwives to register the births they attended was just �vanity� and �gave midwives too much status�. We both know that if the perinatal outcome statistics of LM-attended births (including hospital transfers) *actually* showed the higher rate of mortality or morbidity that the CMA insists to be the case, every one of those lobbyists would be yelling and jumping up and down,  **insisting** that midwives register all their births.

The reality is quite the opposite, both in the statistical outcomes and the behavior of organized medicine. Although Senator Figueroa was successful in changing the birth registration law so that it once again recognizes professional midwife-attended births, the Office of Vital Records continues to make it functionally impossible for the majority of midwives to file birth certificates, thus continuing to obscure the outcomes of LM-attended birth and any realistic appraisal of the safety record of community-based midwifery.

So I suggest this simple test to reveal the motives of organized medicine in regard to these issues. I suggest that you approach the central players (CMA, A\_COG, CAOG, trial lawyers association, etc) and ask what they think of regulations that would require individual midwives to report the number and characteristics of the client population served, emergency transports, any significant morbidity or mortality associated with community-based midwifery care and a mandatory peer-review process for serious morbidity or mortality. The identified purpose of data collection & statistical analysis would be to access the safety of domiciliary midwifery and permit appropriate agency oversight and corrective action (something �supervision� fails at miserably!).

If these lobby groups are genuinely interested in patient safety, as they insist, the first logical step would be for them to demand good data. In this way problems could be corrected and if the care of licensed midwives should actually prove to be unsatisfactory, they would have the �proof� they seek in order to eliminate the current form of midwifery practice. However, if these groups have other, more hidden agendas, such as eliminating the embarrassing contrast between the routine but risky use medical interventions by obstetricians on healthy women and the safe use of physiological management by midwives, they will be uniformly disinterested, or more likely, rigorously opposed. Give it a whirl and see what happens. What is there to loose?

# **"Outcomes of Planned Home Births in Washington State"** ~ There is no way deal with scheduled meetings with organized medicine and debates on �appropriate� midwifery standards without addressing the aforementioned junk science that is the centerpiece of A\_COG�s December 20th letter. **(The text of this critique was reprinted as a stand-alone document** -- [**clicking here**](#30j0zll) **to read)**

I hope you find reading the Standards and Minimum Practice Requirements to be interesting and informative and that you will consider working towards the recognition of California standards for California midwives.

Warm regards,

Faith Gibson, LM, CPM

Executive Director,

ACCM, California College of Midwives

# **"****Outcomes of Planned Home Births in Washington State"**

by Pang *et al,* published in the ACOG Journal, August 2002

# A Critique by Faith Gibson, LM, CPM

# There is no way to debate on �appropriate� midwifery standards without addressing this extraordinary example of junk science. This heavily biased obstetrical research and media sensationalism violates principles of good science in its design, its collection and interpretation of the data, the reporting of its conclusions and its ethical relationship to the scientific community and the public.

# Unfortunately A\_COG would like Board members to think that this study is a comprehensive form of research that defines the scientific literature on the risks of home-based midwifery care. They insist that this one study stands head and shoulders above *all* previous research, negates all previous finding and is to determine, once and for all, that planning a home birth is fundamentally dangerous, end of conversation.

# In other correspondence to the Board I have provided a point-by-point rebuttal of the Pang study. On this occasion however, I would just like to highlight the most egregious aspects of the research.

**Scientific Facts Vs. Educated Guesses:** The Pang study used Washington State birth certificates, which do not record data on the �planned place of birth�, as the raw material for research on planned place of birth. At the same time the researchers chose *not* to use information from any state or any other source that included reliable data on intended place of birth. For example, 20 percent of all births in the US occur in California and our state�s birth certificates *do* indeed include data on planned place of birth. The researchers also ignored all previous studies and the fact that the consensus of the scientific literature, which does have reliable data on intended place of birth, confirms the safety of midwifery care for normal childbirth in a domiciliary setting when the mother is healthy, the pregnancy is normal, and there is adequate access to obstetrical services for complications.

Since Washington State birth certificate data does not provide any way to identify planned place of birth, researchers made up their own definition, one that did not include input from any of the parties with direct knowledge � for example, the parents or the midwife -- and then applied the criteria retrospectively, with absolutely no mechanism to either insure accuracy or detect errors. There is a huge difference between an educated �guess�, which can be neither validated or rebutted, and truly scientific data. One produces valuable knowledge while the other merely impersonates the scientific method for personal or professional gain.

**Inappropriate Inclusions of Premature Births:** To add insult to injury, these suppositions on intended place of birth were also applied inappropriately to a cohort of women who delivered as early as 6 weeks before term. Midwives typically do not attend women at home until after **37** completed weeks of gestation. The functional reason to include pregnancy outcomes starting at **34** weeks was because they needed the additional numbers to make the study data rise to the level of �statistical� significance. However, some medical statisticians have concluded that even with the additional 400-plus premature births in the home and hospital cohort, the study�s conclusions are *still not* statistically valid.

With this spurious definition applied both to precipitously-arising complications (which normally preclude planned labor at home) and premature deliveries, the study inappropriately categorized any woman who delivered a premature baby or had precipitous or complicated birth before the arrival of the midwife (or just as she walked thru the door!) as a �planned� home birth. Under these circumstances, the birth certificate would still be signed by the midwife, even though neither the midwife or the mother �planned� to deliver a preemie or other complicated birth at home. The study also falsely categorized the clients of midwives who developed medical problems during prenatal care and transferred to obstetrical providers as having intended to delivery at home, when in fact they never in any functional way �planned� to have a home birth (i.e., never begin labor at home with the intention of giving birth there).

**Planning Vs. Reality:** If you read A\_COG�s promotion of this study carefully, you will notice that they make much of the idea that it is *the* *planning*, and not the giving, of birth at home that is associated with what they claim to be a higher morbidity and mortality rate. According to this theory, the plan and not the place of birth is the critical issue. One of the reasons is that 269 of the original cohort of 279 complicated midwifery cases were transferred to and the baby actually born in the hospital. However, the 20-foot hole in their 10-foot study is the veracity of the data on intention. While it is unlikely, its theoretically possible that some study may some day establish that  *merely planning* to give birth at home is dangerous. However, *this study* certainly cannot claim to have established that as a scientific fact.

Furthermore, the actual number of perinatal deaths in the Planned Home Birth cohort (PHB) was, statistically-speaking, extremely small. Out of 6,133 babies, there were only 20 perinatal deaths, a number that included 5 deaths that were the result of congenital cardiac disease and 3 babies who died of other major congenital anomalies. If the 8 fatal malformations are subtracted from the total, it leaves only 12 neonatal deaths in the 6,133 PHB cohort. That is 2/10th of one percent or a mortality rate of 2 per 1000. This is consistent with virtually every other published study of home-based birth services provided by trained attendants with appropriate screening and access to medical services. Please note that statistically *both* hospitals and community midwives have an  *identical perinatal outcomes* as measured by morbidity and mortality. However, midwives achieve the *same low rate* with an average operative rate of less than 6%. For the planned hospital birth cohort with the same m&m rate, the average operative rate is well over 30%.

**Missing Data**: The lead author of the study, Dr. Jenny Pang, acknowledged potential problems that were the result of missing or unreliable data. Two important examples are the stats for postpartum hemorrhage (page 6) and assisted ventilation. The PHB cohort of approximately 6,000 births had only 164 missing data sets, while the approximately 10,000 hospital deliveries had 732 missing data on PPH � a factor almost 3 times as high. The missing data for assisted ventilation was even greater � 1170 missing data sets for the hospital cohort (out of 9,423) or about a 12% of the total while there were only 160 missing sets in the planned home birth cohort of 5983. With so much data absent from the hospital cohort no one can say, with absolute confidence as the study purports to do, that the home-birth cohort had �increased� or �excess� PPH and assisted ventilation rates when we actually don�t know what, if any, difference there was between the two groups.

**Excluded Data**: Certain categories of birth outcomes were inappropriately *excluded* from the hospital cohort. The email I received from Dr. Pang stated that they did not include women with cesarean sections and instrumental deliveries since midwives don�t do operative deliveries at home and they were trying to create a parity of cohorts. However, leaving out nearly a third of the hospital births while including a hundred percent of the midwifery clients resulted in a serious disparity that distorted the results.

For example, many of the criteria used to harpoon home birth � especially low 5-minute Apgars and excessive bleeding/PP hemorrhage � would be wiped out by a factor of five or more if that 30-plus percent of operative deliveries had been properly included in the statistical analysis. For instance, the customary definition of a PP hemorrhage is blood loss of over 500cc, and yet the typical blood loss associated with all Cesareans is twice that � 1,000 cc. Regardless of where or how the baby is born -- home or hospital, spontaneous vaginal birth or complicated Cesarean -- the five-minute Apgar is of little diagnostic or predictive significance. It is the persistence of very low Apgars at 10 minutes and beyond, in spite of the use of oxygen and positive pressure ventilation, that is associated with encephalopathy and long-term neurological sequelae.

**Fifteen times more but still invisible:**  One could reasonably expect the hospital cohort to have a Cesarean rate at or greater than 20 percent and a 10-12% forceps and vacuum extraction rate. By comparison, the midwifery cohort only transferred 4% of its entire patient population or 279 women out of 6,133. With a total transfer rate of only 4%, a group that included women who delivered vaginally at the hospital as well as transfers postpartum and neonatal, the cesarean and instrumental delivery rate for the midwifery cohort would be no more than about 2%. This means that the planned hospital birth cohort (of all healthy women) with a total operative rate of 30-35 percent was exposed to *an operative rate at least 15 times higher* than the PHB group. This is a crucial point, as the complications associated with surgical and instrumental delivery � intra-operative, post-op, delayed and downstream � were never acknowledged or accounted for in the study. One of these complications that is particularly far-reaching and tragic is a *13-fold increase in emergency hysterectomies* for women who deliver by Cesarean.

UC Davis obstetrician Elaine Waetjen highlighted the serious additional risks of cesarean delivery in Ob.Gyn.News, 4/1/01, Vol l 36, No. 15, as follows:

**Cesarean surgery causes more maternal morbidity and mortality than vaginal birth.** In the short term, C-Section doubles or triples the risk of maternal death, triples the risk for infection, hemorrhage and hysterectomy, increase the risk of serious blood clots 2 to 5 times and causes surgical injury in about 1% of operations.

In the long term, **cesarean section increases the mother�s risk** of a placenta previa, accreta or percreta, uterine rupture, surgical injury, spontaneous abortions and ectopic pregnancies while decreasing fecundity.

To focus the study conclusions on a small and statistically questionable aspect of this important field of inquiry -- in this case a tiny (and questionable) difference in the number of PP hemorrhage, lower 5-minute Apgar and perinatal mortality in the PHM cohort -- while ignoring the vastly increased risk to mothers (and to babies in future pregnancies) of an operative rate 15 times higher, the inevitable postoperative complications for both mothers and babies in current and future pregnancies, the pelvic floor damage and incontinence associated with anti-gravitational pushing, early and prolonged breath-holding (the Valsalva maneuver) and the use of forceps, other serious iatrogenic complications and dramatically increased economic cost in the hospital cohort is, to say the least, disingenuous.

**Scientific Protocols Vs. Sensationalism:** Lastly is the issue of a shameless violation of scientific ethics by the study authors and by A\_COG. While the study itself was not published until August 2002, the one-paragraph abstract, containing provocative language that the research itself could not support, was promoted to the media four months earlier, in May 2002. This resulted in extensive national media coverage at a time when the full report on the research was still a mystery and since no one can read unpublished research, media reports could not be factually critiqued or rebutted. That means that the PR value (and the predictable damage it caused) was long over before anyone had access to the actual facts.

Even more egregious than the premature timing of the media blitz was the content of the inflammatory and misleading quotes given to the Associated Press (which quickly syndicated it nationally). The headline in the Reuters� news service article (May 8, 2002) by Jacqueline Stenson cryptically encapsulated everyone�s prejudice by stating: �**Home Births Linked to More Infant Deaths**�. Then in typical sensationalized newspaper style, the first sentence in the newspaper story went on to say: **�Twice as many infant deaths occurred during home births than with hospital deliveries�**. These bold statements sounded like irrefutable scientific fact, beyond all doubt. But as we�ve seen, the data and the flawed methodology makes these statements both false and misleading and represents a reckless disregard for the facts.  Even the lead author, Ms Pang, admits in the study itself that:

  �� misclassification might be greater in a home setting than in a hospital  � the magnitude and direction of any such bias cannot be predicted and *so caution should be used when interpreting the results for these outcomes*�. (P.9). (emphasis added)

Leaving no stone unturned, A\_COG used this same provocative vocabulary when it posted the article on the Internet. It seems that they just can�t say their favorite line often enough in regard to midwifery  -- twice as many babies die, twice as many babies die (actually not true) while totally failing to mention that twice as many *mothers* die (scientifically validated ) when Cesarean surgery is substituted for physiological management, not to mention the vastly increased maternal morbidity generated by a 20-plus percent induction rate and 30-plus percent of operative delivery.

There is just no denying that the study design and unethical promotion of its spurious conclusions were the mere impersonation of science. This is the same ignoble strategy that the tobacco companies have depended on for decades.

**Personally, I expected better from the medical profession.**

# **Members, Division of Licensing**

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**Saturday, September 11, 2004**

**RE:  Retirement from my role as Medical Board / Midwifery Liaison**

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Dear DOL / Board Members,

This is a follow-up letter regarding my retirement as liaison between the Board, the Legislature and California Licensed Midwives. As you know, this role was taken over on July 29th by Licensed Midwife Carrie Sparavohn, Chairwoman of the California Association of Midwives.  I will continue to represent members of the California College of Midwives and be available to consult, especially in regard to professionalism of licensed midwives, quality of care issues and the appropriate standards of care for community-based midwifery practice.

I want to thank all the members of the Board and the staff for their kindness and help through out the many years. I know it hasn�t been easy for any of us and I particularly appreciate the many times they went the extra mile on behalf of California Licensed Midwives. Strange as it may seem, I will actually miss you all and my regular attendance at the quarterly Board meeting.

I attended my first Medical Board meeting May 3rd, 1993. In the following 11 years I have been present at two to four meetings each year and attended all seven of the midwifery licensing implementation committee meetings held in 1994. For me, the last decade has been a crash course in administrative law, the medical justices system, the history of midwifery legislation in California and learning about the physician and lay appointees to the Board and the hard-working and dedicated people employed as its staff. I made many important friendships that I will always treasure. I particularly enjoyed being a useful source of information about the physiological management of normal birth, the safety of community-based midwifery and the risks of medicalizing maternity care for healthy women with normal pregnancies.

Unfortunately, the history and circumstances that preceded my political activism on behalf of LMs is not such an uplifting story. From 1981 to 1991 I practiced midwifery lawfully, peacefully and without incident as a Mennonite Midwife under the religious exemptions clause. Without any precipitating consumer complaint or bad outcome, two agents of the Medical Board came to my home on August 9th, 1991 and served me with a criminal warrant charging me with five misdemeanors. I was immediately arrested and handcuffed in presence of my youngest daughter and transport to the Santa Clara county jail, where I was held in solitary confinement for 13 hours until members of my community could raise $50,000 bail. It�s noteworthy that in 1991 the boxer Mike Tyson had just been arrested and charged with felony rape. His bail for rape was $30,000. The misdemeanor charges against me required that my community to pay out $5,000 cash to a bail bondsman. As you know, bail money is a non-refundable fee.

According to a radio news report attributed to the Associated Press, the San Mateo office of the Medical Board stated that I was arrested as a test case in regard to the religious exemptions clause. They were hoping my prosecution would establish a precedent that would eliminate the traditional practice of non-medical midwifery under the religious exemptions clause.  This incident occurred under the direction of Ken Wagstaff, the executive director of the MBC at the time.

# After 20 months of pre-trial hearing (and $30,000 of legal expenses), the DA admitted that the non-medical practice of midwifery was statutorily neutral, i.e., it was *not* a crime. He told my lawyer and me that he was aware of the lack of statutory basis for criminalizing traditional midwifery and said: **�I called those guys at the Medical Board and I told them that if they wanted me to keep prosecuting midwives, they were going to have to get some new legislation passed.�**

# Within a few weeks of this conversation, the criminal prosecution against me was mysteriously dropped (in its 20th month!) and the legality of my practice under the religious exemptions clause was formally acknowledged in the same court documents that dismissed the charges against me. I attended my first Medical Board meeting in Sacramento five days later (May 3, 1993), which was how I discovered that public participation in the public meetings of the agency was virtually non-existent, a fact that I interpreted to mean that crucial element of democratic process � in this case public oversight -- was functionally absent.

# Since the mission of the Board is public/consumer safety, I considered this lack of public participation to result in a patronizing and paternalistic process that was just plain poor public policy. This was the major motive in the many written requests by me for the quarterly board meetings to be video broadcast over the Capital�s cable system, so that citizens all over our great big state could remain informed and informing.  It also explained a lot about how the agency, under Mr. Wagstaff�s command in 1991, could have used its authority in such an irresponsible manner. In targeting me as a member of a class for the purposes of a �test case�, the agency misappropriated the considerable powers of California state government to carry out the long-standing agenda of organized medicine to eliminate all forms of health care by non-physician care providers. I guess I�m just old-fashioned enough to believe that our state government shouldn�t be used to carry water for organized medicine.

# Shortly after the criminal charges against me were dropped, the CMA approached Senator Killea with a deal � if she would let them gut the pending midwifery legislation authored by her in cooperation with the midwives and permit it to be replaced by a licensing statute identical to nurse-midwifery (complete with the same poison pill of mandatory physician supervision), the CMA would guarantee its passage. During one of the Assembly hearing on SB 350, Senator Killea explained to me that: �**Bad legislation is better than no legislation at all**�. With this collection of precipitating events, the LMPA of 1993 was passed and the same Medical Board that was responsible for the arrest and criminal prosecution of midwives was now identified as the regulatory body for midwives like myself. In a nutshell, that is the story of how I came to be traumatically bonded to the Medical Board. �Those guys at the Medical Board� may just be stuck with me for life, as I am a firm believer that the democratic process is a necessary ingredient in any effort to �protect� the public.

In light of these disturbing experiences and my inauspicious entry in the medical justice system, followed by eleven years of representing LMs to the Board, I believe that I have earned the right to offer some observations on the topic of midwifery and the relationship between the Medical Board, professional midwives and the obstetrical profession. At 61 years of age, I am old enough to have seen profound social changes, both in how medicine is practiced and in other topics relative to social justice. I believe in working for social justice. I am fundamentally optimistic that in my life time I will see the end of the prejudice against midwives.

## Background Remarks

But before I get to specific remarks about midwifery licensing, I�d like to tell you two short but informative stories about my early life in a deeply segregated society. As a teenager, my Canadian Mennonite family moved to Florida in 1957 and for the first time in my life, I was exposed to and shocked by blatant and institutionalized racial prejudice.

I attended segregated public schools, I trained as a nurse in a segregated hospital and I eventually provided maternity care in the same segregated institution. Living up close and personal with institutionalized prejudice and government sanctioned segregation I had two very instructive experiences that I want to share with you.

The **first story** is about the public restrooms at a local gas station. Instead of the usual arrangement of two restrooms, one for each gender, the Bay station had three bathrooms. Big signs on each of the three doors proclaimed either �White Ladies�, �White Gentleman� or simply �Colored�. Today we all can see this violation of common decency as emblematic of a morally-bankrupt system that was dehumanizing and wrong. It needed to be changed and eventually it was. Wonder of wonder, I personally lived long enough to see institutionalized segregation in the South come to an end. I believe this to be an example that right does win out if one is willing to work for it and wait for the process to come to fruition.

I had a **second** remarkable and life-changing experience as a nursing student and a staff nurse working in the labor and delivery room of that same racially segregated hospital in the 1960s. Due to its system of medical apartheid, I got to closely observe and directly participate in two entirely different systems, side by side, in the same hospital, at the same time, with the same staff and the same type of patients but totally different management style and outcomes, different as day and night.

It was a naturally-occurring, one-of-a-kind scientific study contrasting two styles of maternity care � a profoundly interventionist model characterized as �knock�em out, drag�em out� obstetrics, versus a lazier-fair system that resulted in,  *ipso facto*, physiologically-managed maternity care. It all depended on whether the mother was black or white.

In our segregated hospital, Caucasian mothers were sent to the all-white labor ward on Five-North. On admission they were immediately given 3 grams of barbiturates (a double dose of sleeping pills). As labor progressed they were injected every 2-3 hours with a narcotic mixture known as �twilight sleep� � large and frequently repeated doses of Demerol, tranquilizers and scopolamine, an hallucinogenic drug that also caused short-term memory loss and amnesia.

Under the influence of these powerful drugs some women became temporarily psychotic and physically fought with the staff and even bit the nurses. Left unattended, they fell out of bed, chipped teeth or broke arms. To keep drugged women from getting hurt, the hospital required a nurse to stay right at the bedside through out the entire labor.  However, we often delivered 8 to12 patients a shift. When the nurses were busy, our white mothers were put in four-point leather restraints, the same ones used in the locked psychiatric wards of the hospital. This forced women to labor flat on their back, a position that interferes with and reduces blood flow to the uterus and placenta, making labor extremely painful and often causing fetal distress.

When time came to give birth, these mothers were moved by stretcher to the Delivery Room, given general anesthesia, put in lithotomy stirrups, a �generous� episiotomy was performed, and the baby was extracted via �low� forceps. One of my jobs as a nurse in the all-white Five-North delivery room was to resuscitate these deeply narcotized and respiratorily-depressed babies. Out of every 25 babies, one or more would fail to establish respirations, thus dying as a result of the drugs, general anesthesia and/ or the use of obstetrical instruments. This high mortality rate was iatrogenic in origin, but that has never been recognized or acknowledged by the obstetrical profession. And yet, this high perinatal mortality rate is still within living memory. For older physicians, these memories add to the mythology that normal birth is intrinsically dangerous and requires many medical interventions.

After the baby was delivered, the obstetrician inserted his hand up into the mother�s uterus to pull out the placenta. Then the episiotomy incision was sutured, with particular attention paid to the so-called �husband stitch�, which was to make things tight for woman�s husband. As an 18 y/o student nurse, I was appalled. It should be noted that the third leading cause of maternal mortality in the 1950 and early 1960s was anesthesia-related deaths.

Then as a student nurse I was rotated off Five North to One South, the black ward in the basement of the hospital. Oddly enough, the maternity care for black mothers was remarkably simple, straightforward, non-interventive, and in my humble 18 y/o opinion, infinitely more humane. It was also psychologically-sound and made right use of gravity. As judged by the number of newborns who did *not* need resuscitation at birth, it was vastly more successful than the highly medicalized care visited on their Caucasian counterparts upstairs on Five North. Frankly, this was all a big relief to me, as I no longer felt that I was being asked to be an agent for a process that was clearly and immediately harmful to mothers and babies.

On One South, there was no labor ward or labor room nurse to care for black mothers. These laboring women were just admitted to their postpartum beds in an old-fashioned four-bed ward. Their labors were not accelerated with Pitocin or any other drugs. Neither were they given medications for pain because the two staff nurses, who were responsible for 40-plus other patients, had no time to labor-sit with drugged and combative women having hallucinations. Besides, in a segregated society, no one much bothered about the labor pain of black mothers, who were assumed to either be tough and able to take it or just out of luck.

However, there were many unintended advantages to this system of purposeful neglect. Because they were unmedicated, our black women in labor were permitted to walk around freely and socialize with the many other experienced women on the ward. This was very comforting to them and provided a useful source of encouragement and tips on how to cope with an unmedicated labor. In particular, our black mothers avoided lying in the bed, preferring to stand and sway or squat during contractions while holding on to the bar at the foot of the bed. When I asked why they didn�t just get in the bed, they looked at me like I must be really dumb and answered in an irritated voice: �Because it hurts too bad when you lay down�. How right they were!

Eventually one of our maternity patients would start to make those unmistakable pushing sounds and so we grabbed a stretcher, threw a sheet over the laboring woman and made a mad dash for the elevator, hoping to get up to the delivery room on Five North before the baby was born. However, so many mothers were high parity that we routinely did not make it. I got my first experience as a �midwife� by receiving the spontaneously born babies of black mothers who delivered on the stretcher in the elevator half way between One South and Five North.

The ease and simplicity of these nurse-managed, non-medicalized births was in stark contrast to the invasive methods used by obstetricians on our Caucasian patients on 5 floors above. As nurses talked these black mothers through the last couple of pushes, their babies just slipped out, with little fuss.  And wonder of wonder, these spontaneously-born *breathed on their own*, since their mothers had not been medicated or anesthetized and no artificial, forcible or mechanical means were used to force the labor or extract the baby. There was no painful episiotomy, no river of blood issuing forth from a gapping perineal wound, no forceps, no fundal pressure, no bulb syringe jammed repeatedly down the baby�s throat, no manual removal of the placenta, no stitches, no post-anesthesia vomiting, no artificial separation of mother and new baby. Clearly Mother Nature, when respectfully supported and un-meddled with, does a darn fine job.

By today�s legal standards these black mothers were actually receiving �substandard� care. Racial prejudice and discrimination of the era had institutionalized the negligent treatment of them and their unborn or newborn babies. Yet, they clearly were getting the better end of the deal, as black mothers were not made to suffer the routine indignities and painful interventions in their labor that were the inevitable lot of while women. The black mothers on One South got safer, physiologically managed labors and normal spontaneous births. As a result, they were not subjected to the labor-retarding effects of social isolation, to being immobilization on their backs with four-point psychiatric restraints, to the maternal effects of being profoundly narcotized or to the slowly healing episiotomy that made it hard to sit and difficult to care for a new baby. Their babies were not exposed to intrauterine narcotics and resulting fetal distress and did not need to be resuscitated, thus contributing to increased IQ points.

When expecting my first baby I took a lesson in childbirth out of that same book. In an attempt to avoid the detrimental effects of these interventions, I asked my obstetrician if I could have the same kind of care that our black mothers received. He smiled and suggested that I just stay out of the hospital until the baby was ready to be born because �that�s what hospitals are for -- drugs and anesthesia�. So I labored at home as long as possible, hoping against hope to have a nice nurse-managed birth on a stretcher in the same elevator on the way up to the Five North delivery room. As luck would have it, I misjudged by just a few minutes. While my husband drove the car, I gave birth alone in the back seat of our Renault, five blocks before we got to hospital. That was the second major area of my experience in midwifery.

## Modern Times, Modern Problems

For the last 100 years the obstetrical profession in the United States has gone to great lengths to convince all of us that physiological management is old-fashioned, inadequate and down-right dangerous. They have purposefully dismantled the infrastructure for providing physiological management, claiming that care for normal childbirth, at least for the affluent and the Caucasian, should consist of a constant stream of medical and surgical interventions provided by physician-surgeons in an acute care hospital setting. When it comes to the astronomical expense of the interventionist model (particularly the maternal choice or �elective� Cesarean), the sky�s the limit, because we are repeatedly assured that this extravagance is buying us better babies.

This is the origin of the conflict we are experiencing today between independent midwifery and organized medicine. They seek to shoot the messenger, as midwives are messengers for normal birth and physiological management. Representatives of A\_COG have appeared before the Board many times, trying to convince you that licensed midwives are dangerous because we do not medicalized normal birth with the routine use of drugs and surgical procedures.

At present, A\_COG has identified a troubling example of biased obstetrical research and media sensationalism as the centerpiece of it objections to midwifery. A\_COG would like Board members to think that this study � �Outcomes of Planned Home Birth in Washington State� -- is a comprehensive form of research that defines the scientific literature on the risks of home-based midwifery care. They insist it stands head and shoulders above *all* previous research, negates all previous findings and is able to determine, once and for all, that planning a home birth is fundamentally dangerous, end of conversation. Unfortunately, this example of junk science violated virtually every principle of good science in its design, its collection and interpretation of the data, the reporting of its conclusions and its ethical relationship to the scientific community and the public. (A brief critique of this study is enclosed.)

However, we all know that if the physiological management of normal labor and birth by professional midwives in non-medical setting *actually* represented the kind of danger that A\_COG repeatedly claims, they would have gone to court ten years ago to obtain an injunction against the implementation of the LMPA and practicing of LMs.  A\_COG didn�t do that because they can�t do that. While these unsubstantiated and self-serving claims may fool the lay public, they do not standup under the rules of evidence in a court of law. A consensus of the scientific literature not only supports physiological management in all settings for healthy women, including both home *and* hospitals, but the scientific literature also comes to the conclusion is that in general physiologically-managed care is actually safer and more cost effective for healthy women than obstetrical intervention. It is the type of maternity care used world-wide. It provides superior maternal-infant outcomes as compared with the United States, with far less expenditure of money and finite medical resources.

Historically the obstetrical profession does not have a good track record at changing its practice as scientific evidence demonstrates that customary treatments are ineffective or harmful. In spite of scientific evidence supporting physiological management as the standard for healthy women, organized medicine tries to justify the medicalization of all normal labors, while it perpetuates its bias against science-based maternity care and its prejudices against midwives. In its own way, it is an institutionalized system of apartheid in which mothers and midwives who employ physiological management are discriminated against. Access to obstetrical services is blocked and when those services become a medical necessity, both midwives and mothers are often the victims of retaliation by angry and outraged obstetricians, who in fact do outrageous things with social impunity.

Before the passage of midwifery licensing laws, the strategy of organized medicine was a sudden-death playoff that used criminal arrest and the prosecution to achieve its goals. Since the passage of the LMPA, the strategy to eliminate professional midwifery is death by a thousand razor cuts, as organized medicine fights the practice of licensed community midwives at every turn, with every dirty trick and with just as much enthusiasm as before. If A\_COG were to wear a campaign button in their war against independent midwifery, they would take their slogan Bull Conner � the infamous, segregationist sheriff of Birmingham, Alabama who wore a button said �**NEVER**�.

The medical profession has always had an extremely contentious relationship with any scientific discover or theory that threatened established doctrines or practices. Notorious examples are the rejection of the stethoscope, the germ theory and accurate understanding of the circulation of blood. Bitter controversies between doctors and other scientists that went on for many decades and many ruined careers preceded the grudging acceptance and eventual widespread use of these discoveries.

More modern example of unscientific and harmful practices includes the routine prescribing of estrogens for pregnant women in the 1950s, which resulted in vaginal and penile cancer in DES adolescents. Even more recent and wide-spread was the routine prescribing of estrogen for post-menopausal women, based on the unproven theory that this drug would to protect against heart disease and cancer when, in fact, it increased the rate and severity of the very diseases it was supposed to prevent. Recent examples that include the same kind of ridicule and vigorous rejection of new theories as suffered by Dr. Semmelweis over a hundred years ago was also visited on Dr. Heimlich, the physician who developed the Heimlich maneuver and the Australian doctor who discovered that the Helicobacter pylori bacteria caused stomach ulcers.

#### The History of Obstetrics

However, it is the obstetrical profession that had and continues to have the most abysmal track record whenever scientific evidence shows their customary practices to be ineffective or harmful. The historical record shows that time and again the obstetrical profession has resisted and rejected scientific knowledge if it refuted their favorite theories or required a change of practices. The most disturbing and well-documented display of this regrettable trait comes from the 19th century story of Dr. Philip Semmelweis, who was a professor of obstetrics at a prestigious teaching hospital in Vienna during the 1840s. Dr Semmelweis amassed incontrovertible proof that purulent organic material carried under the fingernails of doctors and med students caused the fatal puerperal sepsis commonly known as �childbed fever�, which caused the death so many newly delivered women. In his own words Dr Semmelweis concluded that: �puerperal fever is caused by the examining physician himself, by the manual introduction of cadaveric particles into bruised genitalia�

Unfortunately the obstetricians of Dr. Semmelweis� day, like Bull Conner, also said �**never**�, only this time it was to the idea that childbed fever (or any other complication) could possibly be caused by poor obstetrical practices. The specific practice in question was doing vaginal exams on healthy laboring women without having washed their hands between the autopsy room and the labor ward. As a result of this dangerous practice undelivered mothers became contaminated with the haemolytic streptococcal bacteria and developed a virulent septicemia that caused death within 72 hours. During the 18th and 19th centuries ten to fifty percent of maternity patients (both mother *and* baby) died in the teaching hospitals of Europe from haemolytic septicemia. According to historical records, the all-time worst epidemic of contagion occurred at the University of Jena, when not a single mother left the hospital alive for four years in a row.

The �usual and customary� practice of obstetrics in the 19th century included the post-mortem dissection of women who died from puerperal sepsis. In this regard Dr Semmelweis and his colleagues were privy to a lot of educational �opportunities�. In association with these routine autopsies, cadavers were also used to demonstrate the mechanics of obstetrics and permit students to perfect their use of obstetrical instruments. Prior to this era, a biologically-safe teaching manikin, developed by French midwife Madame Cordray, was used to teach midwifery skills to student midwives and instrumental and manipulative obstetrics to physicians and medical students. These life-size teaching manikins each had an anatomically correct pelvis, pregnant uterus occupied by a realistic fetal doll, amniotic fluid, placenta and umbilical cord and access to uterine contents thru a working genital tract.

As dissection became a more important part of medical school education the obstetrical manikin fell out of favor all across Europe. Gradually the bio-safe manikin was replaced by the bio-hazardous cadavers of women who died in childbirth, with the assumption that such cadavers were a �superior� teaching resource that would result in a superior medical education. Each body to be used for teaching purposes was severed in half at the waist, the viscera removed and the uterus dissected out. This was to prepare the amputated and hollowed out lower half of the body to receive a recently deceased newborn, which was placed inside the pelvis for teaching purposes. By passing a series of dead babies down thru the disarticulated pelvis of a recently delivered woman, a professor of obstetrics could control the learning experience and assist his medical students to could carry out vaginal exams, determine fetal lie and position, apply obstetrical forceps, practice fetal destructive operations and learn life-saving maneuvers such as podalic version for obstructed births.

Podalic version was an invasive procedure in which the physician reached up into the uterus to turn a vertex (head down) fetus into a breech position, so that an otherwise undeliverable baby could be pulled out by the feet. Before the development of anesthesia and aseptic technique, which would pave the way for safe cesarean sections, the only choices for an obstructed labor were between a fetal destructive operation or delivering a live baby via podalic version. However, the acquisition of all these life-saving skills by medical practitioners came at an awful price, as the use of cadavers for teaching virtually guaranteed that highly-contaminated organic material would be carried into the labor wards by doctors fresh from the dissection lab. In some hospitals, as many as 700 new mothers (and their babies) died each year, or approximately **two a day**. In Vienna, nineteen hundred and eighty-six women died in Division One at the University of Vienna hospital between 1841 and 1846. In Division Two, the midwifery program staffed by graduate and student midwives, the mortality rate was only 1/5th of that in Division One during the same period of time.

It is important to note then (as now) that many knowledgeable people were critical of the prevailing obstetrical practices. This included other physicians and midwives who were all unwilling to settle for superstitious explanations that blamed these fatal epidemics on everyone and everything else other than obstetrical practices. The director of obstetrics in Semmelweis� time had a fantastic list of 39 incredible �reasons,� such as miasma (bad air), chilling, �milk� fever, errors in diet, maternal emotions that suppressed the flow of the lochia and the �unstable� condition of women. What they all had in common was that each supposed cause was indefinable, untreatable and/or unpreventable and so they completely absolved physicians of any culpability or even the need to search for a cause or a cure. On the contrary, obstetricians got to portray themselves as heroes, saving women from viciously defective reproductive biology, no doubt a lingering effect of God�s curse on Eve.

Over the course of the previous century a small but substantial number of astute physicians all over the world � Doctors White in England, Gordon in Scotland, Cederskj�ld in Sweden and our own Oliver Wendell Holmes in Boston -- had all observed, studied and warned of the iatrogenic nature of childbed fever. Part of the evidence was that the repeated virulent epidemics of puerperal fever were virtually absent in places that midwives (who did not use instruments) managed normal birth instead of doctors (who did) and where autopsies were not being done by the same practitioners who attended deliveries. An article by Oliver Wendell Holmes appeared in the  *New England Journal of Medicine and Surgery* in 1843, entitled �The Contagiousness of Puerperal Fever�. In this he agreed with Doctors White and Gordon that the disease was often transmitted, via an unknown agent, by both physicians and nurses. Unfortunately, these �radical� life-saving ideas were ridiculed and dismissed as absurd by those who thought it inconceivable that the healing hands a physician (or his instruments) could ever, under any circumstances, be a vector for a contagious fatal illness**.**

History records that Dr. Phillip Semmelweis reformed these iatrogenic practices by introducing prophylactic hand washing in a chlorine of lime solution.  Like a sudden overnight miracle, maternal deaths in his institution fell from 18.27% to 0.19% in the eight months between April and December of 1847. As a result he devoted his entire career to preventing unnecessary maternal deaths by teaching and preaching the use of asepsis principles. None-the-less Dr. Semmelweis� simple but effective solution was ignored and ridiculed by his contemporaries, who could not wrap their minds around something so unglamorous and straightforward, something that would have required them to take responsibility for harmful practices. For his trouble he soon lost his prestigious post in Vienna�s most famous hospital, lost his reputation and eventually his profession. As they say �No good deed goes unpunished�. In the end Dr Semmelweis was driven mad by guilt and his inability to �make them listen�. At the age of 47, a mere 21 years after receiving his medical degree, he died in an insane asylum, leaving behind a wife and several children.

The medical profession did not finally acknowledge the role of contagion until 1881, when a French physician, the now famous Dr. Louis Pasterur, established the central role of microbes -- commonly known as �germs� or �pathogens�-- in causing illness and infection. On a chalk board at a prestigious medical meeting Dr. Pasteur drew a graphic representation of what the streptococcus bacteria looked like under a microscope -- rectangular microbes that resembled a string of box cars on a train track -- and said �Gentlemen, this is the cause of Childbed Fever�. With this discovery, Dr. Pasteur delivered the fatal blow to the **erroneous and dangerous doctrine of �spontaneous generation�** -- the theory held for 2000 years that life (and infection) could arise spontaneously in organic materials.

The idea of surgical �sterility� as we know it today is little more than a 100 years old. Before this time the use of invasive techniques and instruments were extremely dangerous and correctly seen by the public as a method of �last resort�. It was not until the discovery of anesthesia in the 1840s to control the inevitable pain of surgery and 40 years later, the germ theory of disease and use of sterile technique to prevent the infection that surgery became a reasonably effective form of medical treatment. The first-ever obstetrical operation -- a Cesarean -- was done in first century Rome to extract a living child from its dead or dying mother. Anesthesia made it possible to do Cesareans on *living women* and sterile technique made it possible for *living women to survive* *the operation*. Episiotomy, forceps and other invasive procedures were also greatly enhanced by the use of anesthesia and sterile technique. Obstetricians had such enthusiasm for these new technologies that it didn�t take long for operative obstetrics to become the �wave of the future�. By  1910, operative deliveries in one famous NYC hospital were already up to 20% of all deliveries or one out of five births.

It would be lovely to report that the obstetrical profession learned a valuable lesson from the regrettable era of Dr. Semmelweis. I�d like to report that the profession had developed the habit of evidence-based practice � scientific inquiry, listening respectfully divergent opinions, taking feedback to heart and putting in corrections as necessary. However, scientific studies evaluating the mortality rate of obstetrical care after the obstetrical profession eliminated the practice of midwifery (approximately 1910 and 1930) showed just the opposite. Instead of the vast improvement they promised, there was a **15% annual increase** **in maternal deaths** for more than a decade and a  **44% increase in neonatal birth injuries** over the same period. The escalating rate of mortality and morbidity was the direct result of replacing the safer, physiologically-based care of healthy women as provided by midwives by routine use of obstetrical interventions including general anesthesia, episiotomy, forceps and manual removal of the placenta.

This highly invasive style of obstetrical care was still in vogue in the 1960s and early 70s when I was a nursing student and L&D nurse. The connection between the history of obstetrics and the issues of  �modern� obstetrics are not as remote as most people might imagine. The reason is the 20th century style of operative obstetrics was actually developed as a correction for the iatrogenic contagion and preventable deaths associated with obstetrical care.

After more than a hundred years of resistance, the obstetrical profession finally acknowledged the contagious nature of puerperal sepsis. Better yet, they embraced the �new scientific method� as hot, sexy and vastly superior to the old days and old ways. Medical men (as they preferred to be called) had always had a hard time distinguishing themselves from midwifery, which was seen as low class, low pay �woman�s work�. The use of obstetrical forceps and podalic version were favorite methods to rise above the low status of midwives, but these were also associated with fatal septicemias. Aseptic and sterile techniques promised to end these problems.

The obstetrical profession assumed (wrongly it turns out), that if labor and delivery were simply conducted under conditions of surgical sterility, all would be well regardless of the number of invasive procedures performed. They assumed that the scientific advances of �modern� medicine would now permit obstetricians to take control of normal childbirth in a way they dared not do before. By conducting normal childbirth as a surgical procedure, they could routinely mechanize it thru the use of anesthetics, episiotomy, forceps and manual removal of the placenta. With this kind of complete control over normal (otherwise unpredictable) biology, they could dramatically speedup the process. Obstetricians theorized that a faster, more controlled process would be better for mothers, babies. And of course that same control and greater speed was more conservative of the doctor�s time, more profitable for the hospital and all around better for everybody. Entirely left out of this picture were the principles of physiological management, which had been happily discarded as irrelevant.

A century earlier, the power brokers of the medical world all turned their backs on any evidence or suggestion that their practices caused or contributed to maternal deaths from sepsis. For the next hundred years, a new generation of obstetricians has turned their backs on physiological process and rejected the principles of physiologic management. Today, the **routine interference in *normal* pregnancy and birth** is the hallmark of contemporary obstetrics, in spite of the fact that this �style� is also illogical, unscientific and harmful. In 1989 Dr. Iain Chalmers, the Oxford University researcher who published the first comprehensive review of evidence-based obstetrical practice (*The Guide to Effective Care in Pregnancy and Childbirth*), bestowed the �Wooden Spoon Award� on American obstetricians, with the disdainful comment that of all the branches of medicine, our obstetrical practices were the *least* scientific.

Like the movie Ground Hog Day or the folk song about the man trapped on the MTA (Massachusetts Transit Authority), contemporary obstetrics has trapped us in a vicious cycle that currently prostitutes the historical ideals of medical care � �in the first place, do no harm�. The issue is A\_COG�s relationship with credible science and whether A\_COG cherry picks its research based on the organization�s hidden agenda. As in Semmelweis� day, modern-day powerbrokers continue to ignore scientific knowledge that is inconvenient, unprofitable, refutes a favorite theory or requires a change of practice. It happily uses junk science in an attempt to discredit physiological management while providing obstetricians with a free pass to employ ever increasing and ever more extreme interventions, including the now popular �maternal choice� cesarean.

**Solutions � Win-Win for everybody**

I am here to testify to two things � Bull Conner was wrong about segregation and so is the obstetrical profession when it comes its prejudice against physiological management and the medical apartheid of midwives. A long over-due and much needed reform of our national maternity care policy will eventually bring an end to Flat Earth Obstetrics. For the first time in modern times, maternity care for all healthy women will be science-based and mother-friendly, which to say, it will integrate physiological principles with the best advances in obstetrical medicine to create a single, evidence-based standard for all healthy women.

When that happens, physiological management will be the foremost standard for *all* healthy women with normal pregnancies, taught to and used by *all* practitioners (both physicians and midwives) and for *all* birth settings (home, hospital, birth center). Then the so-called 'midwife problem' will resolve itself on its own merits.

My question for the members of this august body is simply this: �When history records the story of this triumph of reason over prejudice, which side will you be listed on? Will you know in your own hearts that you did what you could advance both science and social justice? Will your relatives in future generations proudly count you as a patriot for rights of healthy childbearing women to receive safe, cost effective and science-based maternity care?

Today is September 11th, 2004. On that extraordinary day 3 years ago, a lot of ordinary people became heroes because they were brave enough to go up the down staircases in the Twin Towers to help people in need, irrespective of the obvious risk to themselves. Hundred of these ordinary heroes died as a result of their courage and commitment. Mother and midwives are not asking anyone to sacrifice life, limb or livelihood for our cause. **We are however asking for members of the Board to go up the down staircase of medical politics.** We are asking each of you to go the extra mile, to make your decisions based only on the consensus of the scientific evidence and to do the right thing just because it is the right thing to do.

Enclosed as a separate attachment you will find a critique of the study �"Outcomes of Planned Home Births in Washington State", published in the ACOG Journal in August 2002.  I believe you will find this additional information useful in your dealings with representatives of A\_COG.

On behalf of healthy childbearing women and their faithful midwives, I thank you for your time and your attention.

Respectfully,

Faith Gibson, LM, CPM,

Executive Director, American College of Community Midwives

Coordinator, California College of Midwives (ACCM state chapter)

# **Cc:** **All** **Members of the DOL/ MBC**

Anita Scuri, Senior Counsel, MBC

Bruce Hasenkamp, former president, MBC (mailed under separate cover)

# **Enclosure:** Four-page critique of �*Outcome of Planned Home Birth In Washing State*�