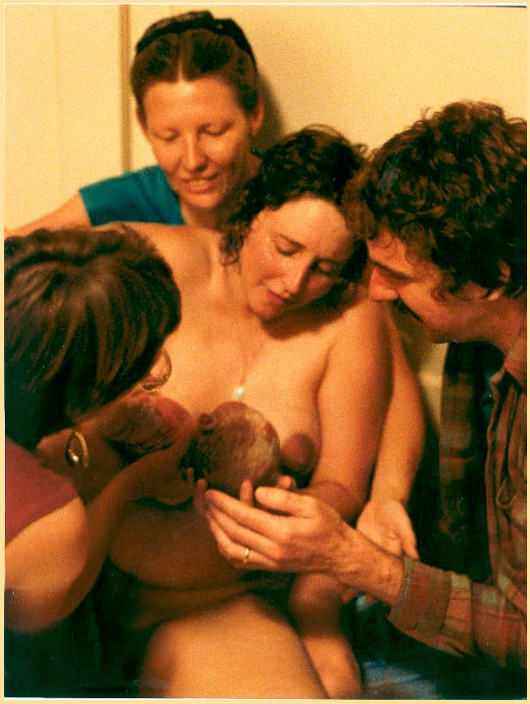
Midwifery in the Ancient and the Modern World



The Bell that Can't Be Un-rung

Faith Gibson, LM, CPM; California College of Midwives

Midwifery, as an organized body of knowledge, preceded the modern discipline of medicine by more than 5,000 years. Depictions of midwifery principles still used today were found among ancient Egyptian hieroglyphics dating back to 3,000 BC. Historically, the art of midwifery was empirically-based and organized around meeting the practical needs of laboring women. The traditional care of midwives included 'patience with nature', the right use of gravity and a commitment not to disturb the natural process.

For healthy women in safe surroundings, childbirth was generally successful for both mother and baby. We know this is true because the human species has survived (and in fact thrived!) into the 21st century. Anyone alive today is a direct genetic descendent of women who were successful at giving birth vaginally, *without* the need for drugs, forceps or cesarean surgery.

Midwifery is not a practice of medicine or nursing but a separate discipline arising in response to the spontaneous biology of childbirth and the physical, psychological and social needs of childbearing women and their babies. This includes the ability to recognize and respond appropriately to complications. In contemporary times, the discipline of midwifery is both art *and* science. Modern midwives are professionally trained and nationally certified to provide evidenced-based maternity

care in homes and hospitals to healthy women with normal pregnancies. Approximately 70% of pregnant women in the United States are in good health and can expect to have a normal birth. This is approximately three million births each year.

The art and science of midwifery is based on the classic principle of **physiological management,** in combination with the best use of modern science. Physiological care is defined as that which is "..*in accord with, or characteristic of the normal functioning of a living organism*". The normal function associated with childbirth is best likened to a slow-motion sneeze – an internally triggered and coordinated process that has been fine-tuned by eons of biological evolution. Like human sexuality, such a masterfully orchestrated function of spontaneous biology is impossible to improve upon but it can be disturbed by those who don't understand the subtle dynamics of this natural energy system.

Physiological care includes the traditional art of midwifery -- 'patience with nature', the right use of gravity, and a commitment not to disturb the natural process. It is a high-touch, low-tech, minimal-intervention model that includes continuity of care, the full-time presence of the caregiver through out active labor, one-on-one social and emotional support and non-drug methods of pain relief such as walking, therapeutic touch and access to deep water tubs. Obstetrical intervention is reserved for complications. It is also available to women who request medical interventions or anesthesia. This functional form of care for normal childbirth is supported by a consensus of the world-wide scientific literature.

According to the World Health Organization, physiological management is the safest and most cost-effective form of maternity care. In the US, it is known as "mother-friendly" care. For healthy women it is the preferred standard and recommended universally for all birth settings and all caregivers – labor room nurses, family practice physicians and obstetricians as well as professional midwives. It is associated with the lowest rate of maternal and perinatal mortality, the fewest medical interventions and a dramatic reduction in iatrogenic and nosocomial complications. It has the best psychological outcomes and the highest rate of breastfed babies. Physiological management is preventive and protective, reducing the episiotomy & operative delivery rate (and associated complications), from approximately 70% of all normal births in the US to only **5%,** with an identical or even *slightly reduced* perinatal mortality rate.

No medical drug or devise, no surgical instrument or procedure ever developed has been able to make birth better or safer in healthy women with normal pregnancies than a spontaneous labor and a normal vaginal birth attended by a trained and experienced birth attendant who has access to appropriate medical services in case of complications.

Sharply Contrasting Opinions ~ the Use of Technology in Normal Birth

In contrast to the ideas above, the obstetrical profession has been convinced for 30 years that medical devises and surgical procedures available only in a hospital could and actually did improve on normal biology and make birth safer. In particular they were convinced that the routine use of continuous electronic fetal monitoring to detect fetal distress, in conjunction with immediate access to Cesarean section to rescue the baby, could prevent newborn brain injuries and thus eliminate cerebral palsy. Unfortunately, the scientific literature unequivocally refutes this idea. Reputable studies, including the American College of Obstetricians and Gynecologist's 2003 'Task Force on Neonatal Encephalopathy & Cerebral Palsy', concluded that:

- Since the advent of fetal heart rate monitoring, there

has been **no** change in the incidence of cerebral palsy.
- The majority of newborn brain injury does **not** occur during labor and delivery.
- … most instances of neonatal [brain injury] and CP are attributed to events that occur prior to the onset of labor.
- If used for identifying CP risk, a non-reassuring heart rate pattern would have had a **99.8% false** positive rate....
- The increasing cesarean delivery rate that occurred in conjunction with fetal monitoring has **not** shown … any reduction in the cerebral palsy rate...
- A physician would have to perform **500** C-sections … **to prevent a single case of cerebral palsy**.

An Unnatural Conflict between Obstetricians and Midwives

Most people are unaware of the controversies and historical tension between the professions of medicine and midwifery and the disagreements about the right relationship between physicians and midwives. At the core of the question about the modern role of midwifery is yet another question -- what is the right relationship between "modern medicine" and so-called "modern" childbearing? This contemporary controversy has nothing to do with the appropriate use of obstetrical medicine to treat the 30% of pregnant women who develop complications. Rather the question concerns using these same forms of medical interventions routinely or "prophylactically" on the 70% of healthy women who have normal pregnancies.

True mastery in normal childbirth services means bringing about a good outcome *without* introducing any unnecessary harm. The fundamental purpose of maternity care is to preserve the health of *already healthy* mothers and babies. Unfortunately, interventionist obstetrics for healthy women introduces unnecessary and artificial dangers in an otherwise normal physiology. This is neither safer nor more cost-effective than traditional forms of maternity care. In the US, interventional obstetrics for healthy women is an "expert" system that has failed *most* in the very area it was supposed to have the *most* mastery and expertise -- "the optimal conduct of the many *normal* cases".

About a century ago, the medical profession made a fundamentally erroneous assumption about the biology of normal childbirth. In 1910, organized medicine officially redefined normal childbirth as a basically pathological process and decreed that every normal pregnancy required the expertise of an obstetrical surgeon to conduct labor as a medical condition and the 'delivery' as a surgical procedure. One effect of this policy was to eliminate the physiological care of midwives. These unexamined ideas were quickly institutionalized in the education and practice of allopathic medicine and resulted in a hundred-year-old failed medical experiment -- interventionist obstetrics for health women as the 'standard' of care in the US. This is the origin of contemporary obstetrics.

For most healthy childbearing women in the US, conventional obstetrics is the opposite of evidence-based, physiological management. It is associated with an average of seven or more significant medical or surgical interventions for every healthy woman who gives birth under obstetrical management. [Listening to Mothers Survey by Maternity Center Association of NYC, 2002]. This system locks healthy women into a one-size-fits-all form of care that is not science-based and does not provide a real choice *or* truly informed consent. Once a woman becomes

pregnant her female biology, in conjunction with the current state of obstetrics, destines her to submit to a risky and interventive form of institutionalized care. This is as immutable an outcome for the majority of childbearing women in America as it is for woman living in many tribal cultures who can be forced as children to submit to genital mutilation and required as a married woman to submit to unwanted sexual encounters.

This routine interference in spontaneous childbearing includes artificially breaking the water, confining the mother to bed with continuous electronic fetal monitoring and IVs, drugs to induce or speed up labor, anesthesia, indwelling bladder catheter, episiotomy, instrumental deliveries and Cesarean surgery. The operative delivery rate for healthy mothers in a 2002 survey was 72% (i.e., episiotomy, forceps, vacuum, or Cesarean). Operative deliveries are associated with post-operative complications including hemorrhage, emergency hysterectomy, pulmonary embolism and infection.

Medicalized labor and operative delivery are also associated with delayed complications such as stress incontinence and pelvic organ prolapse. Cesarean surgery sometimes results in secondary infertility and downstream complications in future pregnancies which include stillbirth, uterine rupture and emergency hysterectomy. Post-cesarean mothers have a higher rate of long-term psychological issues such as PTSD and postpartum depression. Babies born by cesarean section have lower rates of breastfeeding and increased rates of asthma in childhood and as adults.

Cesarean on Steroids ~ the Obstetrical Version of the 'Preemptive Strike'

Since 2000 the obstetrical profession has been formally promoting the “maternal-choice”, (i.e., medically unnecessary) Cesarean as the newer and better way to have a baby. The national C-section rate in 2004 was at an all time high of 29.1% and will be over 30% by the end of this year. One obstetrical expert, when asked why the every increasing rise in Cesareans, likened it to a ‘perfect storm’. He cited obstetrical fears of malpractice lawsuits, the negative influence of continuous electronic fetal monitoring, perceived convenience for both physician and patient of scheduled surgery and the notion (false!) that C-sections protect the mother’s pelvic floor.

Last but not least, he cited “the lack of an opposing view … what we’re not seeing is the push back against these surgeries from the general public, which we saw in the 1980s when the C-section rate was .. 25%. Consumer education groups were very vocal about it and were reassuring women that birth was a natural physiologic process, not a disease. This isn’t something I see as much today.”
[Ob.Gyn.News 12-15-05, vol 40, #24; Dr Bruce Flamm, M.D]

Hospital maternity wards currently being built or remodeled are replacing 50% of the normal labor rooms with operating rooms with the expectation that by 2010 the US will have a 50% CS rate. It’s the “build it and they will come” philosophy. Unfortunately, there are 33 specific route-of-delivery complications -- immediate, delayed and downstream -- associated with Cesarean.

This includes a doubling of the maternal death rate as compared to vaginal birth, which is associated with **only 4** specific route-of-delivery risks for spontaneous birth. According to documents published by the *US Agency for Healthcare Research and Quality* (2003) the typical hospital charge for a Cesarean was $15,591 (not including anesthesia, nursery charges or physician fees) as compared to vaginal birth at home or in a birth center, which was only $1,624. This is basically **ten times** the expense of normal physiologic care.

In the US we have medicalized the biological extremes of the life spectrum, making normal childbirth and end of life care both enormously expensive, all out of proportion to other industrialized countries but without a corresponding improvement in outcomes. This drastically reduces the money and talent available for preventive medicine, wellness education, for developing holistic forms of health care and social support structures for new mothers, disabled citizens, elders and non-medical care for death with dignity.

Problem: The widespread and uncritical acceptance in the US of an unscientific premise -- **surgical obstetrics for normal childbirth,** which includes the routine use of interventionist obstetrics for healthy women with normal pregnancies.

Solution: A science-based care maternity based on physiological management -- safe, cost-effective and mother-baby-father friendly. This would result in a single, evidence-based standard for all healthy women used by all maternity care providers -- family practice physicians, obstetricians, and professional midwives.

Political strategies to Promote Science-based Birth Care . . . .

Many consumers, midwives, other informed citizens and activists believe that science-based maternity care should be the standard in the US. We seek to promote public debate on the rehabilitation our national maternity care policy. Substantial public discourse would include dialogue between childbearing families, scientists, economists and obstetricians and also between obstetricians and midwives. Its purpose would be to integrate physiological principles with the best advances in obstetrical medicine to create a single, evidence-based standard for all healthy women. Physiological management should be the foremost standard for *all* healthy women with normal pregnancies, used by *all* practitioners (physicians and midwives) and for *all* birth settings (home, hospital, birth center). This "social model" of normal childbirth includes the appropriate use of obstetrical intervention for complications or at the *mother's* request.

Management strategies would be determined by the health status of the childbearing woman and her unborn baby in conjunction with the mother's stated preferences, **rather** than by the occupational status of the care provider (physician, obstetrician or midwife). At present, who the woman seeks care *from* (doctor vs. midwife) determines how she is cared *for* -- *physiological* versus *medical* management. This is inconsistent with scientific principles, which identifies physiological management as the foremost standard for safe care.

A rehabilitated maternity care policy would require the medical educators to **teach physiological management** to medical students and that practicing physicians learn and utilize physiological management. It would mandate that **all hospital L&D units be staffed by professional midwives**. It would recognize the fundamental human right of competent, adult women to have control over the manner and circumstances of pregnancy and normal childbirth. It would mandate that truly transparent **informed consent** be obtained before the medical model of care (non-physiological management, immobilization in bed, anti-gravitational positions, etc) and obstetrical interventions are used on healthy women (IVs, continuous EFM, induction of labor, off-label use of Cytotec, epidural, episiotomy, instrumental and operative delivery, etc).

Obsolete policies must be re-thought in light of the scientific evidence. Harmful practices that resulted from faulty premises must be replaced by scientifically-sound, physiological practices. To bring this about we must

mobilize an informed public and a large cadre of knowledgeable professionals who are willing to exercise the rights and responsibilities of citizenship. As agents for change, citizens, consumers and professionals must bring pressure on the political system to reform this important aspect of our health care system. In the 21st century we must make science-based maternity care the foremost standard for normal childbirth and protect the ethical and constitutional rights of competent adult women to have control over the manner and circumstances of pregnancy and normal birth. Pregnancy makes a mother as well as a baby.

A Plan for All Reasons ..

We urge concerned citizens and consumers to join in an effort to replace our expensive and obsolete system with an evidence-based and cost-effective model of mother-baby-father friendly maternity care. An effective political plan should encourage people to:

- Become informed, politically active and discriminating consumers of maternity care
- Create a cohesive, broad-based and effective constituency made up of consumers, taxpayers, childbirth and public health professionals committed to reforming our maternity care policies
- Create a single, evidence-based standard for all healthy women.
- Bring about legislative hearings on the issues noted above, including the off-label use of Cytotec for labor induction, the ever-climbing cesarean section and maternal mortality rate, the danger in promoting the maternal choice cesarean as an idealized form of childbirth, etc
- Facilitate legislation mandating that physicians obtain truly informed consent from healthy women before substituting medical and surgical interventions in the place of the safer, evidence-based principles of physiological management and provide full information about the risks of medical or surgical intervention they recommend.
- Promote investigative journalism in regard to the use of obstetric interventions on healthy women
- Work for the rehabilitation of our national maternity care policies relative to mother-baby and father-friendly systems that are ‘efficacious’ – that is, *both* safe *and* cost-effective.