California College of Midwives

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Mothers Day, 2000

Dr. Steven Polansky, CAOG Board Member

California Association of Obstetricians and Gynecologists

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Re: Factually incorrect Quotes in San Diego Union Tribune 4/22/00

Dear Doctor Polansky,

Members of the *California College of Midwives* are acutely aware of the crucial role that obstetricians play in our lives and those of our clients. Generally speaking, midwives have a natural affection for obstetricians and are seeking to dramatically improve the quality of the debate between our respective groups and the public at large. There are many areas of mutual concern. Our goal is to better the working relationships between physicians and community midwives so that mothers and babies do not suffer as a result of the historical tension between our groups. In light of our attempts to facilitate a good relationship, we were disturbed to read comments by you as a representative of *CAOG* that are factually incorrect and which fuel animosity between doctors and midwives. This is misleading to the public and to members of the Legislature and especially detrimental to mothers and babies who depend on the compassionate and unbiased care of obstetricians when risk factors or complications arise necessitating transfer of care from midwifery to medical management.

As a representative of a scientific discipline, I’m sure you realize the burden placed on you to communicate only scientifically valid information in a public forum unless your statements are identified as merely a personal opinion. **The very fact that you are the holder of a doctorate gives the public every good reason to believe that statements made by you and other doctors are factually correct and scientifically-based.** You were quoted in the *San Diego Union Tribune* identifying the controversy over SB 1479 as definitely not a "turf issue" but rather a "a safety issue". The opinion was ascribed to you that it was inherently safer for children to be born in a hospital, that CNMs should practice only in the hospital and {licensed} "lay" midwives shouldn’t be allowed to practice at all. I must mention here that technically speaking, a state licensed midwife has been identified as a competent professional by the Medical Board and is no longer correctly referred to as a "lay" practitioner.

If one examines your remarks in the *San Diego Union Tribune* and the host of similar remarks by spokesmen for organized medicine reiterated over the course of the last 100 years, the inescapable conclusion is that each and every professional midwife providing home-based care is consistently responsible for causing the death and permanent disability of innocent women and helpless babies which would have been prevented had they *only* been in the care of a physician or labored in a hospital. **Unless you have irrefutable evidence --** *accurate historical and contemporary vital statistics in combination with scientifically valid studies proving that more mothers and babies die or are damaged when cared for by midwives than when giving birth unattended or attended by doctors* **-- then your claim is a libelous one**.

During a recent hearing in the Virginia State legislature an *ACOG* representative testified in opposition to midwifery licensing. At the conclusion he was asked by a senator if he had any evidence that home birth is unsafe or that nationally certified professional midwives are not performing well in other states. His answer was "**No. No evidence**."

Anti-Midwife Rhetoric Is Unfounded

Your organization’s anti-midwife, "homebirth is unsafe at any speed" rhetoric is only defensible as a partisan political opinion. Otherwise it leads readers to arrive at several false conclusions as no scientifically-validated data establishes any of your assertions -- that it is inherently safer for healthy women with normal pregnancies to give birth in hospitals under obstetrical care, or that for "safety" reasons CNMs should only provide care in hospitals and that licensed midwives should not be permitted to practice at all. A large body of respected scientific literature has for the last 100 years documented the relative safety of midwife-attended birth for healthy populations in non-medical settings. More than 100 scientific studies, peer-review articles and reports from the World Health Organization statistically support the efficacy of domiciliary midwifery services for low and moderate risk women. In contrast, not a single study has ever been published proving hospitals to be a safer place for this same low risk population to give birth or establising obstetricians to be safer caregivers for healthy women.

Scientific literature all over the world the identifies professional midwives to be the most efficacious category of caregiver for healthy women with normal pregnancies. Virginia’s Governor Gilmore proclaimed May 5th (International Women’s Day) to be Midwives Day in his state, praising "the positive impact that midwives and the Midwifery Model of Care have had on improving infant mortality rates and decreasing the incidence of complications and unnecessary medical interventions during childbirth," benefits which are, he concluded, "recognized throughout the world by leading health organizations." This acknowledgement does not negate the equally compelling fact that 99% of childbearing women in the US prefer to give birth in a hospital, 94% prefer physician-only care and 80% prefer epidural anesthesia for delivery. **Domiciliary midwifery will naturally remain a minority choice** as it will never be safe to use narcotic pain meds or epidural anesthesia at home, something most women prefer and which requires hospitalization. But regardless of the respective market share of the two systems, the midwifery model of care is dollar for dollar, good outcome for good outcome, the best buy. In many European jurisdictions the law actually requires a midwife to be involved in all vaginal births.

Vital Statistics on Midwife-Attended Births

One source of reliable evidence that should be able to settle the controversy are state records of vital statistics on planned home birth attended by California’s professional midwives (CNMs and LMs). However this avenue was actively blocked by organized medicine which lobbied hard (so far successfully) to prevent midwives from being able to register the births they attend. Absence of these vital statistics and other sources of accurate data prevent your organization from making the claim that midwives provide a dangerous form of maternity care or promoting any other official position that is derogatory to licensed midwives in California as contrasted with hospital obstetricians.

Were your statements as quoted in the *Union-Tribune* to have been based on actual scientific facts your membership would have been ethically obligated seven years ago to seek an injunction to prevent the implementation of the licensed midwifery law and to sponsor legislation preventing any professional or lay person from attending a labor or birth at home while legally mandating that all resident pregnant women receive obstetrically-based hospital care during the intrapartum events, even if such arrangements are at taxpayer expense. We noticed that your organization has elected not to do any of these things, no doubt due to the indisputable fact that such claims could not be substantiated nor would they be politically popular (or even feasible).

Malpractice Prevention

Physicians have nothing but negative things to say about mothers laboring at home under the direct care of a skilled midwife but choose not to acknowledge the irony of the current system in which mothers labor in the hospital *while their doctors are at home* *or across town at the office*. A physician lawyer (David Rubsamen) conducted a study of 63 lawsuits against obstetricians due to neurologically damaged babies. Dr. Rubsamen identified the absence of the physician (or other authorized practitioner) from the immediate area of the laboring women and lack of (or disruption in) continuity of care as a major factor in the events leading to litigation.

In approximately 60% of these cases mis-communication occurred between the physician who typically was not present (or not awake) and the L&D nurse, making it the most frequently preventable factor relative to brain damaged babies, expensive litigation and multimillion dollar judgments against physicians and hospitals. These are described by Dr Rubsamen as one of several "malpractice traps" that makes "obstetrics a loss leader for professional liability insurance carriers throughout the US". Unfortunately, this problem continues. The April 2000 issue of *Contemporary Ob/Gyn* reported a recent malpractice case in which the physician blamed the nurse for not notifying him of late decels and poor fetal heart rate variability over a four hour period of progressive deterioration. The nurse insisted that the physician (who was not in the hospital) had been telephoned and appropriately informed. Situations of this type would be prevented under the midwifery model of care in which the full time presence of the practitioner is routine.

A Plan for the 21st Century ~ Workable Midwifery Laws

Midwives and home birth families would like to see the energy currently expended in fighting against home birth midwifery be redirected into more beneficial pursuits. For the last 30 years a steady 1% of childbearing women have chosen to give birth in a non-medical setting, usually their own homes. Of particular note is the greatly increased safety of having a skilled midwife attendant with a perinatal mortality of 1-3 per 1000 live births (current national rate is 7 per 1000) versus infant death of 30 to 60 per1000 for unattended or "do it yourself" deliveries. Mothers that seek out midwifery care have already declined conventional obstetrical services -- it is the presence of a trained attendant which makes this a safe choice. The best option, given these realities, is for your organization to support a workable midwifery law, one that adequately protects all parties (including mothers and babies) and which includes a "*hold blameless for care not rendered*" clause for obstetricians and other medical careproviders.

*ACOG* officially supports freedom of choice for childbearing women in its abortion policy statement (page1067 of *ACOG Compendium 2000*) regarding informed consent which notes **"informed consent is an expression of respect for the patient as a person; it particularly respects a patient’s moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities and to support of the patient’s freedom within caring relationships".** We are suggesting in the strongest terms that you not restrict your official respect for informed consent and your organizational support of the "patient’s freedom within caring relationships" only to women choosing a doctor to abort a pregnancy while denying it to those who choose to maintain their pregnancies while receiving care from a community-based midwife. It sends the wrong message, one which I am sure is not intended.

Remarks made by your organization misrepresenting the choice of a community midwife as unsafe, uninformed or immoral must be replaced with a public acknowledgment that each type of caregiver (physicians and professional midwives of all backgrounds) and all settings for labor and birth have identifiable benefits and specific risks. The real issue is *fully informed consent relative to the available choices*. I was a labor and delivery room nurse for 20 years before cross-training into midwifery and accompany all my transfer clients (about 23% for primiparas) into the hospital and remain with them until the baby is born. I have been a close observer of routine hospital care since 1961. It is consistently clear that the more you "do" to the healthy laboring mother in the way of obstetrical routines and "just in case" interventions, the more you have to "do", medically and surgically speaking, to keep things on tract. Any nurse who has worked five or more years in L&D can tell you that medical interventions are a big factor in increasing the frequency of operative deliveries with additional pain and risk, disruption in the parental-child bonding process, prolonged hospitalization, added financial cost to insurers (and thus to employers and taxpayers) and increased litigation. Were midwifery management made available to every hospitalized woman the ratio of these interventions, added cost and complications would be reduced.

Single Standard of Care, Internally-Consistent Practices

The idea may seem shocking at first but I suggest that a great burden would be lifted from obstetricians and midwives both to have a single standard of care relevant to the physical, psychological and social needs of childbearing women, rather than our current system that depends instead on the category of caregiver for its standards of practice. At present the "right" care for a healthy laboring women is defined differently if that care is being rendered by a board-certified obstetrician than by a family physician, a CNM or a community-based midwife. The real issue is not the routine of a particular discipline but what is best for that particular mother under the individual circumstances of her specific labor. The category of caregiver and the duties required of professionals should reflect the best of evidence-based practice parameters as related to the woman’s situation and her informed consent decisions.

In an integrated system the provision of maternity care would occur along a co-ordinated spectrum, with midwifery and obstetrics at opposite ends of a continuum, spanning the most simple to the most complex. Respective expertise of all caregivers would overlap in the middle of the spectrum but would not be identical. Both disciplines would continue to benefit from the abilities of the other. At one end would be a small number of midwives caring for healthy mothers in the setting of their choice. At the other end of the continuum would be the increasing complexity of medical treatments, hospitalization and a modest number of obstetricians, perinatologists and other medical specialists caring for highest risk pregnancies and sick neonates. In the middle, caring for lots of health women and babies, would be lots happy hospital-based professional midwives and family practice physicians. In this configuration, everyone would be singing from the same hymnal for the first time in a 100 years. Many areas of practice among the four major categories would be essentially the same regardless of type of caregiver. This would give midwives and physicians a chance to learn from each other, develop internally consistent practices and give rise to an elevated standard of care that spans the full spectrum of modern-day maternity care.

The Midwifery Model of Care

Brings Midwives and Physicians Back Together

I would imagine that your organization is familiar with one of the largest consumer groups -- *Citizens For Midwifery* founded by Susan Hodges. This national organization promotes the midwifery model of care as the most appropriate form for healthy women with normal pregnancies who do not plan on using pharmaceutical pain management during labor or anesthesia for delivery. It identifies the *Midwifery Model of Care* as monitoring the physical, psychological and social wellbeing of the mother, providing her with individual education, counseling, prenatal care and continuous hands-on care through out labor and birth, minimizing technological interventions, identifying and referring women to physicians who require obstetrical attention and providing individualized postpartum support in the weeks following the birth. This traditional model of maternity care is statistically associated with a reduced incidence of birth injury, trauma and cesarean section. Obviously, physicians as well as midwives can provide care under the principles of midwifery management, either personally or by employing professional midwives to provide care to healthy women.

Many other consumer advocate and Internet groups have been formed in the US to bring about a fundamental change so that America can join that large group of nations in Western Europe, Japan and elsewhere with excellent perinatal outcomes and affordable maternity services directly attributed to their policy of supporting and promoting the midwifery model of care. Changes being pursued by these groups include the recommendation that primary staffing for all hospital L&D rooms be by nurse-midwives; that the full-time presence of a practitioner (either physician or professional midwife) be routinely required at the bedside while the woman is in active labor; a national campaign to raise consciousness of the problem of unnecessary episiotomies and re-defining the routine use of episiotomy as a form of genital mutilation; improvements in medical education so that hospital midwives instruct medical students in the principles of normal birth before students are exposed to obstetrical pathology; re-defining the normal "standard of care" for healthy women to be the midwifery model and establishing the legal theory that standard midwifery methods be employed first and foremost, before it would be considered appropriate to utilize obstetrical interventions (for example, use of non-pharmaceutical pain relief measures before offering epidural anesthesia; utilizing upright and mobile maternal postures during the pushing stage prior to recommending operative delivery for failure to progress).

Futures Market ~ "Off-Site Birth Technology"

I often wonder why obstetricians don’t seem interested in being part of this active dialogue so that your membership can have a voice and vote in how these changes come about. The midwifery model of care is the next frontier of the public health movement. Hospital-acquired infections and medical errors kill more than 80,000 patients annually which means that well-run domiciliary services spare healthy childbearing women from unnecessary risks and save the public from the added expense of paying for these complications. If I were an investor looking for a futures growth market, I’d buy stock in companies that made increasingly affordable miniaturized birth technology (such as the *Baby Dopplex 3000* from Huntleigh in the UK or their brand new "**Fetal Assist**", a 6" x 10" x 2" battery-operated 2# computerized electronic fetal monitor which analyzes the FHT pattern, allows one to chart in "real time", store records on multiple patients, has a modem connection and other wonderful features; the affordable Palco pulse oxymetry by a start-up company in Santa Cruz or portable ultrasound like the 5 # hand-carried SonoSite 180). This would permit any couple planning to labor at home to rent an "off-site birth technology kit" from their local hospital (paid for by health insurance) which would include the same modest number of medical surveillance devices routinely available in any community hospital. These would be utilized as appropriate by a well-trained community midwife to monitor the mother and baby.

I’d also encourage hospital administrators to look at the physical building as merely the hub of a wheel, with little satellite "labor rooms" all over their catchment district as healthy low risk moms are cared for at home in their own bedroom (with suitable technology) by a professional midwife who can, if indicated, transfer the mother in to the hub/hospital to take advantage of more sophisticated technologies and physician services. If I were a professional educator I’d start designing curriculums to formalize the cross pollenizations between physicians and midwives, providing opportunities for each to learn from the expertise of the other. If I was an ostrich, I’d just stand there with my head in the sand, **eyes wide shut**, hoping that after a 10,000 year history of midwifery as a successful and sought after system of maternity care and the recent licensure of more than a hundred community midwives in California (plus 15 other states), midwives and the women who want home-based birth services will all just disappear as if my magic and things will go back like they used to be, before managed care spoiled the party.

Keeping place of birth from becoming an issue of safety

When it come to claims that I and other professional midwives harm healthy mothers and babies by offering care to them, I must insist that you stick to the facts and just the facts. I take comments such as appeared in the *Union Tribune* as a personal insult. I have never had a "bad outcome" that was the result of an inappropriate decision by the family to labor at home or from any professional error or inability on my part. Among the dozen or so midwives I regularly work with, good outcomes are the norm. I know of only a tiny handful of home births over the course of the last decade in which a preventable bad outcome occurred, a ratio no different from that affecting other forms of health care providers. It is mutually advantageous that midwives and physicians stop trolling each others problematic outcomes looking for fodder for gossip columnists. Lets just stick to evidence-based practice parameters and a realistic assessment of the literature on place of birth as a safety issue, as the only relevant conversation is how to work together to keep place of birth from becoming an issue of safety.

An exchange of expertise is long overdue. It is as much the responsibility of physicians to be familiar with the time-honored philosophy, principles, techniques and skills of midwifery as it is the duty of midwives to know the principles of anatomy, asepsis and how to recognize complications. Midwives universally agree that modern obstetrics has much to teach and much to contribute to the wellbeing of the families it serves. As midwives we have already availed ourselves of both formal and informal study of obstetrical science. Likewise, the honorable but unassuming traditions and unique abilities of midwifery -- the art of being "with women", a quietness of spirit and patience with nature and the intimacy skills which serve childbearing families so well -- are also of great value to the bio-medical sciences and society at large.

Correcting the Public Record

Speaking for California’s professional midwives and childbearing women (as a mother and grandmother myself I care very much about the quality of maternity care available to my daughters), I ask that you and other members of the *California Association of Obstetricians and Gynecologists* cease and desist from any further claims promoting the notion that midwives harm healthy mothers and babies simply by being permitted to provide care. This categorical condemnation of all licensed midwives by your organization is unwarranted. It is just as outlandish as the idea that all obstetricians are suspect because one in New York carved his initials into the abdomen of his patient. Please note -- midwives did *not* use news of that outrageous story to suggest that obstetricians should only be allowed to practice under the supervision of professional midwives.

In light of the body of published information identifying the efficacy of the midwifery model of care and the absence of evidence that home birth is categorically unsafe or that midwives routinely render unsafe care, we are asking you to provide corrected information to the editor of the *Union Tribune* and request that a correction be published. Studies comparing physicians and professional midwives are relatively equal in perinatal outcomes with some researchers showing a slight benefit for low risk mothers who labor in a domiciliary settings, along with a significant reduction for this OOH cohort in the number of obstetrical procedures and sequelae. In future public interviews we expect you and other representatives of your organization to either acknowledge these facts or identify your remarks as a personal or a political opinion*. Please provide a written response to this request within 30 days.*

Faith Gibson, LM, CPM

Director, *California College of Midwives*

cc: Planned Parenthood

National Organization of Women

Don Thompson, Associated Press

Dr. Thomas Joas, MD, Members, MBC

Bruce Hasenkamp, Members, MBC

Linda Whitney, staff, MBC

Julia De Angelo-Fellmeth, Citizens for Public Interest Law

Senator Liz Figueroa, Author SB 1479

Jay De Furia, Senate Business and Professionals Committee

Joseph Cotchett, Law Offices of Cotchett, Pitre and Simons

Frank Cuny, California Citizens for Health Freedom

Susan Hodges, Citizens for Midwifery

Coalition for the Improvement of Maternity Services (CIMS)

Deanne Williams, CNM, American College of Nurse Midwives