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| Spotlight  Story for  week of  10/17/97 | October's  cover story  Minnesota  Parent Magazine | Midwives Under Fire    by Katie Allison Granju |

Katie Allison Granju is a feelance writer based in Knoxville, TN. She writes frequently on health and parenting topics for a variety of publications and is the mother of Henry, age 6 and Jane, age 2, both of whom were born in a hospital with an OB in attendance.

[katie@esper.com](mailto:katie@esper.com)

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Quick: what is the world's oldest profession? The answer is almost certainly midwifery. By providing comfort, care, and safety for other women during the natural processes of pregnancy and childbirth, wise women known as midwives have been an integral part of women's health services from the beginning of recorded history. Today, midwifery care still exists as the basis for maternity services in almost every nation, with seventy-five percent of Western European births attended principally by midwives. Most nations' health-care policies are in agreement with the World Health Organization's statement that "the curricula for the education of all health professionals should reflect the role of the midwife as the primary care giver in maternity care."

Yet, maternity care in the United States stands in stark contrast to the rest of the world, with five percent or fewer of all American births currently attended by midwives--and even then, the midwife in attendance is typically under the close supervision of a physician in a hospital. Powerful lobbying groups such as the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) frequently assert that women prefer obstetricians because physicians provide better maternal- and infant-health outcomes than do midwives practicing either inside American hospitals or outside of them (birthing centers and home births). In fact, however, overall U.S. infant-maternal health statistics rank far behind (21st in infant mortality) a number of other industrialized nations, most of which utilize the midwifery model of care: according to the Midwives' Alliance of North America, in the five nations with the world's lowest infant mortality and lowest rates of technological intervention, midwives attend seventy percent of all births without a physician in the birth room.

Moreover, many studies in recent years have demonstrated the safety and efficacy of midwifery care here in the United States: in a 1994 study reported in the medical journal ***Birth***, 6,944 midwife-attended, planned out-of-hospital births were scrutinized by researchers and outcomes were found to be comparable or better than those obtained by physicians in hospitals. Meanwhile, no study has ever revealed superior health outcomes for women with healthy pregnancies who receive their care from an obstetrician as opposed to a midwife.

Other research has demonstrated significantly lower rates of interventions such as Caesarean-section and episiotomy, and higher rates of patient satisfaction among pregnant American women receiving midwifery care. According to a recent article in "Baby Talk" magazine, certified nurse midwives offer a Caesarean-section rate of less than twelve percent, compared to a national rate of over twenty-one percent. An even more startling difference was discovered in a 1992 study in the American Journal of Public Health in which over 1,000 planned, direct-entry, midwife-assisted home births were compared with approximately 14,000 statistically matched hospital births. Only 2.11 percent of the women who gave birth at home experienced such interventions as forceps, vacuum extractors, or C-sections, while 26.6 percent of those giving birth in the hospital encountered these outcomes. Lastly, because a typical midwife-assisted package of prenatal and birth care costs thousands less than seeing a doctor, Frank Oski, MD, director of pediatrics at John Hopkins University School of Medicine, has estimated that the United States could save over ten billion dollars per year in health-care costs by utilizing midwives as primary care givers in pregnancy and childbirth.

What's going on here? Why aren't more women in this country taking advantage of the proven advantages of pregnancy and birth care offered by midwives? The answer is perhaps inherent in the American medical establishment, and the persecution and control with which it has historically beset the profession of midwifery. American women make millions of visits to obstetricians every year, and the typical hospital birth now costs as much as eight thousand dollars. Birth is big business. Each time a woman chooses to utilize a midwife for her pregnancy and birth care, a doctor and possibly a hospital have lost a potential consumer.

Paul Lewis, Midwife and Academic Head of Midwifery at the University of Bournemouth, England, UK, says that midwives around the world are appalled by American physicians' treatment of midwifery. "The domination of American maternity care by a powerful medical profession has nothing to do with the best interests of women or babies and more to do with the self-interest and the financial gain of the medical profession," he asserts. "This is clearly seen in the poor birth outcomes in your country when compared to other countries with similar or even worse economic standing. The World Health Organization has stated in unambiguous terms that in societies in which midwives are employed to assist women giving birth, the outcomes are, in nearly all instances, better than those societies in which only doctors are involved."

In 1847, when the American Medical Association was founded, virtually all American babies were still being ushered into the world by a midwife. The number of midwife-assisted births remained high in the United States well toward the end of the nineteenth century, when physicians began to decry the lack of suitable "teaching material" in the form of pregnant women upon which budding obstetric-surgeons could practice their techniques. According to certified professional midwife and author Faith Gibson, the American medical establishment began the organized campaign against midwives that continues to this day between the years 1910 and 1920, at a time when women still did not have the vote. Gibson, in her treatise "The Official Medical Plan to Eliminate the Midwife--1910-1930," quotes one doctor's words from 1911:

". . . the teaching material in New York is taxed to the utmost. The 50,000 cases delivered by midwives are not available for this purpose. Might not this "wealth of material" [emphasis mine] be gradually utilized to train physicians?"

In addition to worries over this "waste of clinical material" to midwifery care, American physicians in the early part of this century were openly concerned about the economic revenues lost to midwives. In one published report, physicians actually calculated how much more money they could make if midwives were driven out of business in the United States. This effort to eliminate midwives from the U.S. medical-care system was not unique in a global historical context: during the infamous European witch trials of the Middle Ages, midwives and other women healers were a primary target of persecution. In 1484, Pope Innocent VIII made an official declaration against the crime of witchcraft, which was codified in a volume called Malleus Maleficarium. This book became extremely influential and was utilized by European judges and magistrates for over 300 years. Women of all stripes were tried and executed as directed by this book, but midwives were declared to be the most dangerous criminals extant. Malleus Maleficarium states:

"Midwives cause the greatest damage. Either killing children or sacrilegiously offering them to devils. . . . The greatest injury to the Faith are done by midwives, and this is made clearer than daylight itself in the confessions of some of those who are afterwards burned."

John Robbins notes in his book, Reclaiming Our Health (HJ Kramer, Tiburon, 1996) that during this time in many European villages, every female was murdered, including children and the elderly. Another medieval scholar has estimated that that more than one million midwives and healers were tortured and murdered during this period. Witch hunters were clear in their assertion that the ability of midwives to relieve the suffering of other women was the real crime. One wrote:

". . . By witches we understand not only those who kill and torment, but all wise women who heal, save and deliver."

Witch-hunters of the Middle Ages referred to midwives as "crones," "hags," and "filthy." Perhaps not coincidentally, American physicians of the nineteenth and twentieth centuries have often used these same terms when discussing this continent's midwives. Comments by various physicians of the early part of this century include:

"[She is] pestiferous . . . the typical old, gin-fingering, guzzling midwife, . . . her mouth full of snuff and her fingers full of dirt."

And:

"The midwife is a relic of barbarism. In civilized countries the midwife is wrong and will always be wrong."

Despite their own history of persecution and harassment, European midwives were able to make a comeback in the centuries that followed the witch trials. The Age of Enlightenment and later scientific inquiry demonstrated to European policymakers that health outcomes for women were better and costs were lower when trained midwives were utilized as the front line in maternity services. In the United States, however, the campaign to eliminate the midwife altogether through law and ill-informed public prejudice was largely successful. State by state, organized lobbying efforts convinced middle- and upper-class women that they should see a male physician, and state legislatures began to outlaw or restrict the profession of midwifery.

By the early 1960s, fewer than one percent of American births were being attended by midwives. But it was also during the '60s that some American women began questioning birth practices as promulgated by the now-dominant male medical establishment. No longer willing to be strapped down to a metal table, drugged into semi-consciousness, and "delivered" of their babies by the obstetric-surgeon's knife or forceps, a minority of women began educating themselves and seeking out the few remaining midwives in the United States for maternity care. Demand began to grow, and by the 1970s, despite the fact that the practice of midwifery was now actually illegal in many states, the number of midwives in this country was again slowly on the rise, a fact that the AMA and ACOG could not fail to notice. Awareness of midwifery in the U.S. has been growing ever since: the American College of Nurse Midwives reports that while only five percent of this country's births are attended by midwives, preference for in-hospital, midwife-attended births in the United States actually grew from about 20,000 in 1975 to almost 200,000 in 1994. There are now approximately ten thousand midwives practicing in this country--still many fewer per capita, however, than in other Western nations.

As this ancient profession first awakened from its slumber, American midwifery branched into two distinct schools--a situation in marked contrast to other countries, and which some observers see as a "divide and conquer" strategy supported by physicians. Many consumers are not aware that there are two types of midwives now practicing in the United States: nurse-midwives, who practice under the supervision of physicians in hospital settings, and direct-entry midwives, who practice primarily in birthing centers and home settings.

Although certified nurse-midwives (CNMs), accredited by the American College of Nurse Midwives (ACNM), are now licensed in all fifty states, they are required to practice under the strict supervision of a physician, often limiting their ability to provide maternity care significantly different than that typically offered by an obstetrician. In fact, Deanne Williams, Director of Professional Services for ACNM, reports that ninety-four percent of CNM-attended births still take place in the standard hospital setting. "No doubt about it, many nurse-midwives would like to practice outside of the hospital in a birth center or home setting," says Williams. "Unfortunately, most are unable to find a physician--who will offer the oversight that the law requires us to have--who will allow this type of autonomy."

There is currently no significant push within the ACNM for nurse-midwives to establish a truly independent profession, although the ACNM recently introduced a highly-controversial educational path for non-nurses to receive a type of ACNM certification. Critics assert that CNMs have allowed themselves to be subjugated by the medical establishment in return for a modest level of cooperation from medical doctors--striking a veritable "deal with the devil" in order to to avoid elimination by American physicians. ACOG's position is that nurse-midwives provide acceptable care as long as they work in concert with a supervising physician (emphasis mine). Most nurse-midwives today work in hospitals and OB/GYN offices alongside doctors and other nurses. Bruce Flamm, MD, FACOG and the author of Birth After Caesarean Section: The Medical Facts (Prentice Hall Press, 1990) wrote in Midwifery Today that "Nurse-midwives seem to be moving more toward the obstetrical philosophies, assimilating the new technologies, and many actually view themselves as part of the medical establishment."

By contrast, the other type of midwife practicing in the United States today, the "direct entry midwife" (DEM), has always existed as a professional distinct from and independent of physicians. As with the European model of midwifery training, the DEM learns her extensive skills without first passing through a nursing curriculum. The many DEMs in the United States who acquire professional certification do so through the North American Registry of Midwives (NARM) after completing NARM's credential-earning process and passing a rigorous exam. DEMs practice independently of physician supervision but refer those patients with high-risk conditions to appropriate care by a medical doctor. Supporters of the DEM model of midwifery care don't necessarily consider a nursing curriculum essential for safe, high-quality birth care. One nurse midwife quoted in Reclaiming our Health said that the arts of nursing and midwifery are "really quite different" and reported that what she learned in nursing school was "quite irrelevant" to attending births."Nurse-midwife has the same ring to me as ballerina-carpenter," she commented.

The direct-entry midwife's ability to practice in the United States today varies greatly from state to state, with several state governments providing licensure and insurance funding, and others actually arresting direct-entry midwives for such things as "practicing medicine without a license." The AMA and ACOG continue to take the official position that direct-entry midwifery, even with professional certification, is not safe or advisable for pregnant women in this country. This mind-set has managed to permeate much of mainstream American culture: the "pregnancy bible" of the 90s, What to Expect When You're Expecting, states unequivocally that the only type of midwife that can provide safe or effective care in pregnancy is a nurse-midwife. A recent article in Baby Talk magazine--distributed in doctors' offices nationwide--entitled "Should You Use A Midwife," virtually ignores the existence of DEMs, instead focusing on CNM care in a hospital. The article does, however, refer to the "risks" of DEM care, and quotes a doctor who says that he knows physicians who believe that ". . . anyone stupid enough to attempt a home birth deserves whatever happens to them."

The most current pregnancy manual distributed to tens of thousands of American women by this country's OB-GYNs and produced by ACOG, Planning for Pregnancy, Birth and Beyond, contains the following statement: "Babies can be delivered by three types of health care providers: certified nurse-midwives, doctors in a family practice, or obstetrician-gynecologists." This attitude persists in spite of numerous studies which validate the safety records of well-trained DEMs, including one 1987 study reported in the American Journal of Public Health in which 4054 Missouri births were reviewed. The direct-entry midwives participating in the research had better outcomes than either physicians or certified-nurse-midwives.

Because very few DEMs in this country are allowed into hospitals and because many hold the philosophy that childbirth is not a pathology requiring hospitalization, the vast majority of DEM-assisted births take place in a home or birth-center setting. The AMA and ACOG further oppose birth at home, again in contradiction to the safety evidence readily available in current medical literature. The World Health Organization recommends that national maternity policies reflect a preference for midwife-supported, planned out-of-hospital birth, and a November, 1996 study in the British Medical Journal verified that planned home birth is a safe option for women with healthy pregnancies. Many medical policy analysts and consumer advocates believe that, although major medical groups continue to attempt to couch their opposition to independent midwifery in concern for "safety," in reality, economics and a lingering sexism (direct-entry midwifery involves women caring exclusively for women) play crucial roles in the these groups' opposition to the profession.

Susan Hodges, director of the Georgia-based national nonprofit group "Consumers for Midwifery," says that midwifery is caught in the middle of the national health-care crisis as physicians attempt to hang on to their turf: "Midwifery has always been maligned by the medical profession. As these economic turf wars increase in intensity, doctors malign midwives and out-of-hospital birth, nurses malign nurse-midwives, and nurse-midwives malign direct-entry midwives," she explains.

And in the current political environment, American DEMs risk much more than disapproval from the medical establishment by practicing their chosen profession. Roberta Devers-Scott, a DEM from Syracuse New York, was arrested in her office in December, 1995 following a sting operation carried out by two undercover agents from the NYS Office of Professional Discipline. Devers-Scott was charged with "practicing medicine without a license." However, New York State doesn't offer any mechanism by which a DEM can become licensed. Devers-Scott, with an impeccable record of safety, was trained at a fully-accredited midwifery program where she acquired more clinical hours than the State University of New York's own program required. Many other DEMs in New York have also experienced legal threats and charges in recent years.

In 1994, the California Board of Medical Quality Assurance sent armed agents to the home of a southern California DEM, and they held her thirteen-year-old daughter on the floor at gunpoint while they searched her home in order to build a case against her for the practice of midwifery. The same year, Lynn Amin, the licensed owner of an out-of-hospital birth center in Riverside, California, was arrested and chained to a wall in a jail cell with her hands cuffed behind her back for many hours. Amin's partner, Lorri Walker, a registered nurse-practitioner, was entrapped by undercover officers posing as a pregnant couple. When she started to take the woman's blood pressure, she was arrested and handcuffed.

These cases represent only a few out of dozens across the country in which midwives with excellent safety records have been threatened and harassed by medical and legal authorities. Ann Cairns, Public Education Chair for the North American Registry of Midwives, points out that unlike obstetricians, midwives aren't being sued by hundreds of grieving parents every year for poor outcomes, yet midwives are the ones upon which untold numbers of taxpayer dollars are being wasted on schemes to see them arrested. Donna Read, producer of the highly acclaimed historical documentary on the medieval witch trials titled "The Burning Times," says that she sees the modern-day persecution of American direct-entry midwives as part of a "continuum" stretching back to the witch hunts of the past.

Currently, a number of DEMs in Illinois are being served with "cease and desist" orders from the Illinois Department of Professional Responsibility (IDPR). The IDPR claims that these midwives have been practicing medicine without a license. Like many other states, Illinois does not offer a process by which even a certified professional midwife can become licensed. Additionally, midwives and their medical supporters dispute that midwifery is actually "practicing medicine" since pregnancy and birth are normal physiological processes which generally require no intervention other than observation. This contradicts sharply the position of most medical doctors, who see childbirth as a pathological event fraught with risk and requiring medical management and oversight. Bruce Flamm, MD, OB-GYN, says that "obstetricians have been taught that pregnancy and labor are disasters waiting to happen."

Richard L. Garrison, MD, Assistant Professor, Department of Family Practice and Community Medicine, University of Texas, Houston Health Science Center, says that this nations' stance on planned home births stems from unfamiliarity: "They [OBs] are not trained for handling normal labor and delivery, and they perform poorly when asked to do that for which they are untrained. Second, they are reluctant to train for it because their entire model is an intervention-into-pathology paradigm. They will deliberately avoid being placed in a situation where maximum use of intervention is not available. They would consider the home as birthplace 'primitive' or 'Third World.'" Further articulating the pregnancy/ birth-as-pathology viewpoint is Stanley K. Peck of the Connecticut Department of Public Health, quoted after the arrest and trial of direct-entry midwife Donna Vidam in 1995. Peck stated that women do not have the right to choose to give birth with a midwife at home "any more than they have a right to brain surgery at home."

Paul Lewis of the University of Bournemouth sees this mischaracterization of childbirth as a risk factor unto itself. "I do recognize the need for medical involvement when women have high-risk pregnancies or serious complications occur. However, we know from the research evidence that if low-risk women are cared for alongside high-risk women, that the former soon have applied to them the strictures intended to safeguard the latter. The problem with this approach is that such strictures carry risks in themselves and the complications of such treatments usually result in low-risk women becoming high risk."

Susan Hodges of Citizens for Midwifery says that this conflict regarding the essential nature of childbirth represents the primary difference between the American medical establishment and direct-entry midwives. "In the midwifery model of care, the midwife responds to the birthing mother's wants and needs. The mother births her baby. In the medical model of care, the doctor "delivers" the baby. What, then, was the mother doing?" she asks. "This said, I would also point out that when there is pathology, physicians, hospitals, and technology can save lives, although doctors might be more effective if they served as consultants to midwives and adopted the midwifery model of care."

In the current climate of medical hostility toward midwifery, pregnant women can be the real losers in the rare case when a physician is needed. At present, midwives are often unable to forge alliances with competent backup physicians and may even be afraid to accompany a laboring client into the hospital for fear of harassment or arrest.

Although Minnesota's midwives have not been subject to arrest, the state does not currently offer any mechanism by which certified DEMs can obtain a license. A state midwifery task force has been meeting for the past several years with the ostensible goal of devising a state licensure process for Minnesota's DEMs such the ones available in states like Alaska, Florida, Arkansas, Washington, and New Mexico. Although national midwifery advocates see this as a hopeful sign, Minnesota midwives remain frustrated with the pace and tone of the task-force hearings. DEM Jill Kent of Hendrum, Minnesota was a member of a previous state task force and says that she can't understand why, as Minnesota's only practicing Certified Professional Midwife, her input hasn't been welcomed by the current incarnation of the task force.

"Watching the dynamics of these hearings has been sad. Members, including doctors, walked into the meetings without any background knowledge or information on this important national and state health-care issue. One member even asked that the hearing time be used to bring her up to speed on midwifery issues, " says Kent. "I don't consider it very professional to agree to serve on a task force and then appear at the meetings with no understanding of the topic under discussion, especially since the Minnesota Midwives Guild will eventually bear the cost of these meetings." Kent notes that Minnesota has a "very powerful chapter of the American Medical Association" and says that the state has one of the nation's highest concentrations of practicing obstetricians. Susan Hodges of Citizens for Midwifery believes that it is unethical for a task force deciding the fate of one profession--midwives--to be staffed with members belonging to a competing profession--obstetricians.

Jill Kent agrees. "The doctors on this task force know that if I were able to get state licensure to open a midwife-staffed birth center, I would have so many clients tomorrow that I couldn't keep up with the work. They know that the demand is there from Minnesota women for more birth options and frankly, it probably frightens some of them."

Despite the difficult conditions under which American midwives continue to practice their chosen work, there are signs that the climate for midwifery may be changing. As research mounts in support of the safety and efficacy of midwifery care, it is unlikely that a nation struggling to pay spiraling health-care costs can long ignore this economical option in maternity services. The state of Florida recently bowed to the fiscal benefits of midwifery care and began actively encouraging the training and use of both CNMs and licensed DEMs by the state's citizens. "If we are to make real progress in providing primary and preventive care and in reducing infant-mortality rates," says Florida's Deputy Secretary for Health, Charles Maham, MD, we must broaden our provider base by encouraging the growth of midwifery."

However, according to Susan Hodges, the greatest hope for change is from pregnant women themselves. "Even if doctors did not oppose home birth and midwifery, and laws are changed, mainstream beliefs will still have to change. Many people are now so dissatisfied with the health care status quo that they are more open to new ideas and changes, and that is hopeful for midwifery," she says. "In any case, as long as even a minority of women wish to be attended by direct-entry midwives, such midwives should be available and legal for all who want them."

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She may be reached at [katie@esper.com](mailto:katie@esper.com)

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**SIDEBAR**

An Interview with Midwife Ina May Gaskin

by Katie Allison Granju

Ina May Gaskin, Certified Professional Midwife, has been described by Jan Tritten, editor of Midwifery Today, as "the mother of authentic midwifery." As the founder of the seminal out-of-hospital birth center in the United States, located in Summertown, Tennessee, and the author of Spiritual Midwifery (The Book Publishing Co., 1977), Gaskin has had a profound impact on the resurgence of direct-entry midwifery in the United States since the early 1970s. Today, Gaskin serves as editor and publisher of the periodical Birth Gazette and is an internationally known speaker on maternity care issues in her role as spokesperson for Midwives Alliance of North America (MANA).

KAG: What is the role of MANA and how many members does the organization have?

IMG: We have 1,000 members. MANA's goals are: to expand communication and support among North American midwives; to form an identifiable and cohesive organization representing the profession of midwifery on a regional, national, and international basis; to promote guidelines for the education of midwives and to assist in the development of midwifery education programs; to promote competence in midwifery practice, midwifery as a quality health care option, research in the field of midwifery care, communication and cooperation between midwives and other organizations concerned with improving perinatal outcome; and to support a woman's right to choose her care provider and place of birth and further public education and advocacy.

KAG: What is your position on the CPM credential?

IMG: I am a Certified Professional Midwife. I believe that certification is one important way of helping the public to know that the certified (direct-entry) midwife has passed an examination created by experienced, knowledgeable midwives and that she has demonstrated her mastery of requisite midwifery skills, and can document a minimum level of experience previous to certification. While I am in favor of decriminalization of all midwifery (for public health reasons), I believe that it makes sense for certification to be required.

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