

Midwifery's Renaissance

Dismissed, disrespected, and hunted like witches, midwives are finally being recognized-but misunderstandings and myths endure

—By Marsden Wagner, *Born in the USA*
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Because the midwives feared God, they did not do as commanded by the king.
-Exodus 1:17

A midwife is lectured at by committees, scolded by matrons, sworn at by surgeons, bullied by surgical dressers, talked flippantly to if middle aged and good humored, seduced if young.
-London Times, 1857

After working as a practicing physician for several years, I became a perinatologist and perinatal scientist, as well as a full-time faculty member at the Schools of Medicine and Public Health at UCLA. Then I became a director of maternal and child health for the California state health department. In that capacity, I learned that in the rural town of Madera, California, doctors had decided that they no longer wanted to attend births in the Madera County Hospital. They complained that it took too much of their time and didn't pay enough. So in 1968 the county recruited two midwives to fill the gap. After two years, the rate of babies dying around the time of birth in the hospital was cut in half. Alarmed that their style of maternity care was being made to look bad, the doctors in town agreed that they would once again attend births in the hospital if the two midwives were fired. The hospital fired the midwives, the doctors returned, and soon the rate of babies dying around birth rose to its earlier higher levels.

This natural experiment comparing the safety of doctors and midwives left me confused and full of questions, because, in spite of my years of experience as a physician, I had no real knowledge of midwifery. What are these midwives? How are they trained? Could it be that, as seen in Madera County, they are generally safer birth attendants than doctors? Through no fault of their own, Americans, including obstetricians, have little understanding of midwifery. In the early years of the 20th century, a witch hunt against midwives in the United States and Canada eliminated midwifery as a legitimate health profession. The profession has gained ground in the past two decades, but most people today have no personal experience with midwives and have been exposed to considerable misinformation about midwifery.

From California I left for Europe, where I joined the staff of the World Health Organization. There I was exposed to the essential role midwives play in maternity care in other highly industrialized countries and in developing countries.

Throughout history, there have always been women in the community to whom other women can turn for support with concerns—not just about reproductive health care but also issues such as spousal abuse. The word *midwife* is early English for "with woman." The French term for midwife, *sage femme* (wise woman), goes back thousands of years, as do the words in Danish, *jordmor* (earth mother), and in Icelandic, *ljósmodir* (mother of light).

In the fifth century B.C. Hippocrates formalized a midwifery training program in Greece. Phaenarete, the mother of Socrates, was a midwife. In the Bible, the Book of Exodus recognized the strength and independence of midwives who defied the pharaoh's command that they kill all sons born to Hebrew women. The first law to regulate midwifery in Europe was passed in Germany in 1452 and required that a midwife attend all births. Since then, every little girl in Europe has grown up with the understanding that if she has a baby, a midwife will assist her.

When Europeans migrated to the New World, midwives were among them. Midwives were a valued part of the developing health care system in colonial times, and by the mid-1880s they were teaching medical students in at least one university.

As the number of physicians increased in the United States, medical doctors attempted to monopolize health care through state medical practice acts that defined health care parameters, including who can practice. By the end of the 19th century, it was common for midwives to be accused of witchcraft and tried in court, and midwifery practice began to disappear. The case of Hanna Porn was one of the most famous and had far-reaching consequences. In Gardner, Massachusetts, in 1909, a judge sentenced Porn to three months in prison. Her crime? She was a practicing midwife. Fewer than half as many of the babies whose births she attended died as babies whose births were attended by local physicians. But the Massachusetts Supreme Judicial Court used her

case to rule that midwifery was illegal in Massachusetts, based on the testimony of physicians who said that midwives were incompetent. Other states followed suit and made midwifery illegal, and it remained illegal in nearly all states for more than 50 years, until nurse-midwifery began to be legalized.

Despite this attempt to dismantle the profession in the United States and Canada, midwifery continued to thrive in Europe and other parts of the world. And while the profession was severely hampered in the United States for decades, it was not stamped out. Throughout history, every attempt at ending the practice has failed. It seems that there will always be women who want to be midwives and women who want midwives to attend them when they give birth.

When officially sanctioned midwifery was attacked in the United States, midwives went underground. Women who became known as "granny midwives" (because they tended to be older) continued to practice, especially in poor communities. In the 1920s Mary Breckinridge, a public health nurse and midwife, formed the Frontier Nursing Service to provide maternity care to families in rural areas of Appalachia. Some of the staff members formed an organization that later became the American Association of Nurse-Midwives, as well as the Frontier School of Midwifery and Family Nursing, which trained hundreds of women in what became a new profession in America, nurse-midwifery.

The number of nurse-midwives grew, and by 1977 the profession was licensed in every state. After nursing school, a nurse can elect to go on to midwifery school for about two years and become a nurse-midwife. This is not the same as becoming a labor and delivery nurse, a nursing specialization that has no training requirement and usually involves about six weeks of on-the-job training.

Women can also train as "direct-entry" midwives, going directly to midwifery school without training first in nursing. Direct-entry midwives have grown steadily in numbers and recognition. In 2006 direct-entry midwifery was legal in 24 states, "alegal" (allowed without legal interference) in 17 states, and explicitly illegal in only nine states. In the past decade, more and more states have been legalizing direct-entry midwifery. The U.S. government recognizes the training for both nurse-midwives and direct-entry midwives and has authorized the Midwifery Education Accreditation Council to accredit midwifery schools and programs.

Despite the current resurgence of midwifery in the United States, the fact that midwives were harshly persecuted for more than a century has left the profession with a legacy of public reticence and confusion that must be overcome. Many myths surround midwives, myths that are often reinforced by obstetricians who view them as competition. One is that midwives are not trained but are "hippy-dippy" lay women who attend only home births. Another is that midwives are religious zealots or witches who use magical potions. That nurse-midwives attend births only in hospitals is a common misconception, as is the idea that a midwife is a second-class doctor for women who can't afford a real obstetrician. None of these ideas is remotely true. Science has proven that for attending low-risk births (that is, births without complications), midwives are not second-class obstetricians, but rather obstetricians are second-class midwives.

Generally speaking, a fundamental difference between midwifery care and physician care at birth has to do with control. Childbirth is a complicated physiological process regulated by the woman's nervous system. Childbirth is not under the conscious control of the woman giving birth, but rather is directed by hormones and the parasympathetic portion of the autonomic nervous system. Anything that causes fear or alarm shuts down the parasympathetic system and fires up the sympathetic nervous system (adrenaline). Any intervention that increases a laboring woman's fear or anxiety will interfere with, slow down, or even stop the birth processes. A wise birth assistant, be it midwife, nurse, or doctor, knows how to facilitate these autonomic responses and not interfere with them. The key elements in the midwifery model of birth are normality, facilitation of natural processes (with minimal intervention), and the empowerment of the birthing woman.

Taking on the role of facilitator, midwives typically will reassure, calm, and encourage birthing women. Obstetricians, on the other hand, typically try to get the birth under their own control by overriding the natural processes with drugs and medical procedures and giving orders. The medical model and the midwifery model are essentially different ways of looking at women and birth. Doctors "deliver" babies and believe that having a baby is something that *happens* to a woman. Midwives assist at birth and believe that giving birth is something that a woman *does*.

Midwives tend to believe that a woman giving birth needs to be the one making decisions about her birth experience. The woman giving birth needs to believe in her own body and feel responsible for her body, while at the same time letting go of the need to control what is happening, since she cannot.

Another fundamental difference between midwives and doctors is how they view pregnancy and birth. Midwives understand that pregnancy is not an illness. They typically call the women in their care "clients," not "patients," since they are not sick and are not getting medical treatment. Though midwives know what can go wrong during pregnancy and birth and know how to identify problems early and to cooperate with doctors in managing complications, their focus is on birth as a life-enhancing experience. Although they believe it is essential to have

medical assistance available when it is needed, they are trained to go beyond medical care and empower women to achieve their goals for themselves and their babies. Midwives trust in women's bodies and their capacity to give birth successfully with little or no intervention in most cases.

Obstetricians, on the other hand, tend to focus on what can go wrong during pregnancy and birth. All doctors have been trained to look for trouble (diagnose a problem) and decide what to do about it (decide on a treatment), and that is what comes naturally to obstetricians. In prenatal care they take the same approach, focusing on what can go wrong.

Another important difference between midwife-attended low-risk birth and obstetrician-attended low-risk birth is the quality of the experience for the woman. Many surveys have shown that women who have midwives as their attendants have far higher levels of satisfaction with their birth experience than women who have obstetricians attending their births. This is not hard to understand. Midwives give great attention to building close relationships with their clients and their clients' families.

Generally speaking, midwives are direct, open, and honest in their dealings with clients and take an egalitarian, intimate, woman-to-woman approach. Midwives do not guarantee a good outcome, and their honesty about their role and its limitations contributes to the level of satisfaction women feel with their services. On the other hand, in a doctor-patient relationship, there is no egalitarian tradition. Rather, the doctor's superior knowledge and status are for the most part unquestioned and there is a belief (or hope) that the doctor can perform miracles.

Midwives, like doctors, are human. They have bad days and they make mistakes. Science now tells us, however, that overall, midwives are safer than doctors for low-risk births. If a woman is among the 80 to 90 percent of all women who have normal pregnancies, the safest attendant for her hospital birth is not a doctor but a midwife.

In the past two decades we've seen a renaissance of midwifery in the United States. Each year, the number of births attended by midwives increases.

The more the practice of midwifery grows and succeeds, the more threatening midwives are to the obstetric monopoly, so, predictably, there has been an obstetric backlash. Now, a hundred years after Hanna Porn was persecuted, we have another American witch hunt against midwives. In many states, doctors are reporting midwives to various authorities as dangerous.

In many cases, these attacks are simply attempts by doctors to eliminate the competition. Cases against midwives are, with very rare exceptions, not initiated by the families the midwives serve, as is typical of litigation against obstetricians. Instead, they are initiated by physicians. In the past several years in many states, including Illinois, Utah, California, Vermont, Virginia, Nevada, Oregon, Indiana, and Ohio, police have arrested direct-entry midwives for practicing nursing or medicine without a license.

Maternity care in the United States is changing, and one of the most important changes still in progress involves who will catch the 3.5 million babies a year whose mothers have had normal pregnancies. That is, who will be the primary birth attendant for low-risk births? In the past decade, the percentage of births attended by midwives has gone from 5 percent to 10 percent, and there are a few places where it is closer to 25 percent. HMOs are hiring more and more midwives. Kaiser Permanente, one of the largest HMOs in the country, has many midwives on its staff. There are several reasons for the growth of midwifery in the United States, and a big one is money.

Midwifery is far cheaper than obstetrics for two reasons. On average, obstetricians take home a net income in the neighborhood of \$200,000 a year, whereas midwives earn about one-quarter of that. Equally important, the cost of the obstetric interventions, such as induction and C-section, performed unnecessarily can easily be cut in half by having midwives, rather than obstetricians, assist at normal births. Health care in the United States is very much driven by the bottom line, and slowly but surely the insurance companies, managed health care organizations, HMOs, and even state and federal government agencies are realizing that the obstetric monopoly is wasting enormous amounts of money. The day that truth fully sinks in will be the day the obstetric monopoly is on its way out.

As midwifery becomes better established in the United States, it becomes more difficult for the obstetric establishment to perpetuate the myth that midwives are not as safe as doctors. Pushing the "safety" issue has backfired as a way for obstetricians to protect their territory. As more state legislatures look carefully at the data and realize that they have been denying families a safe maternity care option, momentum will grow and laws that support and protect midwives will spread to other states.

Another reason midwifery is going to grow: Americans believe in a free market economy with open competition. Obstetricians and midwives both offer primary maternity care.

Finally, midwifery will continue to grow as more women come to appreciate that maternity care is not primarily a health issue but a women's issue. Midwifery plays an important role in strengthening women's control over their own bodies and reproductive systems.

Excerpted from Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First (University of California, 2006).