New pro-midwife guidelines have recently been issued in the United Kingdom. But in the United States, doctors are all too often the gatekeepers for women’s birth care.

A few months ago, I was bumped from a national radio show. The choice of topic—midwifery—was precipitated by the new U.K. guidelines urging that healthy, low-risk women consider midwife-led, out-of-hospital options for birth as a safer alternative to hospital birth. Right before the producer hung up on my first conversation with her, she mentioned she had some doctors to talk to before she’d know if I would “fit” on the panel. I thought, “Oh, here we go again,” and asked, “Can I just say one more thing? I know you have to talk to the doctors, because they’re the ‘experts,’ right? But this is the changing conversation in maternity care. Women are smart enough to make these decisions. Women have the right to make these decisions. Women want midwives.”
This isn’t the first time the press has had to defer to doctors about the topic of midwifery. But one thing I’m sure that the general public and the media don’t understand, after constantly deferring to doctors on this issue, is that doctors are the main reason women don’t have midwives.

A Conflict of Interest

In the early 1900s, the burgeoning American medical lobby was nearly successful in stomping out their competition, including what the Journal of the American Medical Association and others called “the midwife problem.” Through calculated smear campaigns this group portrayed midwives as unskilled, ignorant and dirty. By the middle of the century American birth had shifted from home to hospital, under the authority of doctors. Against the strategic efforts of moneyed white men to co-opt childbirth, midwives were left disenfranchised.

The whole story is fascinating and I encourage anyone who is interested to explore it. It is the story of how an enterprising medical profession institutionalized childbirth and subjected numerous women to unconsented medical experiments. As Marjorie Tew summarized in her 1998 article “Safer Childbirth? A Critical History of Maternity Care”: “At every level of predicted risk [for birth] measured, high and moderate as well as low, perinatal mortality was highest by far for births in hospitals and lowest for births at home.”

Since then, midwifery has had to crawl its way back up to the present hodgepodge of different types of midwives, with various credentials and training, and a mishmash of state laws and rules that range from “Sure! Go get yourself a midwife!” to “If we catch you with a midwife, she’s going to jail.” One credential—that of Certified Nurse Midwife (CNM)—has found more acceptance in the medical community, but nurse-midwifery no longer resembles its origins of women on horseback delivering excellent care to the homes of other women in rural Kentucky. Now, 95 percent of nurse midwives work in hospitals, most under the supervision of doctors. Women, therefore, aren’t just working with the midwife they’ve hired; they’re working with what the midwife’s backing physician, other physicians, and the institution will “allow.”
Things are better than they were, but nowhere near where they should be. Today, the American College of Obstetricians and Gynecologists (ACOG) refuses to recognize the midwives who attend around 80 percent of births outside of hospitals. ACOG does not support programs that advocate for, or individuals who provide, home births. Thus they do not embrace the position of their maternal health colleagues who believe all birth should be where women decide to give birth.

It’s actually harder than you’d think to find places where a woman is free to independently hire a midwife without the imposition of third-party supervision. Here’s one of many true stories about how this looks in real life. When a certified nurse midwife respected a client’s right to give birth in whatever position they liked (because she knew that restricting women’s movement and positioning in labor could impede labor and injure the women or the baby), an obstetrician from a different practice caught wind of it. When he heard that the midwife’s client gave birth on her hands and knees on a blanket on the floor he complained to the hospital, triggering new policy. Now, the midwife’s clients must give birth in bed, like everyone else.

So what does it matter that this woman has hired a midwife when a random obstetrician can take her choice about how to give birth right out of her hands? This clues us in to why women are hiring midwives in the first place: We don’t always like to be told “how to give birth.”

No Way Out

Women are still subject to practices that have been proven harmful for decades: denying them food and drink in labor (60 percent of labors in the U.S.), restricting them to bed (76 percent) on their backs (92 percent), and tying them to continuous electronic fetal monitoring (94 percent). In some facilities, policies of physical force are used when women don’t comply with provider preferences. What happens to women who choose out-of-hospital care? It can be difficult for them to find doctors who will provide prenatal consultation, for one. Some women will forfeit their wish to give birth at home for fear of reprisals should they end up needing to transfer to a hospital in labor. I have spoken with women from all over the country who say they have been bullied, refused care, and treated with violence as home-to-hospital transfers. Louisiana mother Andrea Davis uses words like “violated,” “raped,” and “shame” to describe her experience after she transferred to St. Tammany Hospital (which features a 45.1 percent Cesarean rate!) simply because she was exhausted after 24 hours of labor. Her story is not uncommon, and it’s not hard to understand why neither women nor their midwives would want to transfer into this kind of setting. It’s not hard to understand, either, why a woman wouldn’t choose that kind of environment for her birth in the first place.
Sociologist and professor of obstetrics and gynecology Raymond DeVries observes how other sociologists have “noted that licensing laws...have given professionals and their associations a restrictive monopoly over practice,” making it “a criminal offense for the unlicensed to take any action specifically reserved for licensed professionals.” He further notes the cozy relationship between the professional associations and the public agencies meant to act as regulatory and disciplinary bodies, quoting Ronald Akers’s study, “It appears that their activities, personnel, and even finances overlap to such an extent that it is not entirely correct to say that the association ‘influences’ the board’s administration of public policy....The cooperation between the two sometimes reaches the point of near identity.” In other words, when medicine decided to “professionalize” childbirth, it simply staked out the boundaries and set up shop with the blessing of the state. Indeed, women are giving birth within the limits of what looks a lot like a monopoly. Their frustration has fueled grassroots efforts all over the country to reform, improve and expand maternity care. But these consumer-fueled efforts routinely meet with opposition and resistance.

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<th>What is Midwifery?</th>
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<td><strong>Midwifery Model of Care</strong></td>
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<td>Woman is primary actor (&quot;births&quot; baby as &quot;client&quot;)</td>
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<tr>
<td>Provider is primary actor (&quot;delivers&quot; baby from &quot;patient&quot;)</td>
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<td>Labor and birth are supported as normal life events</td>
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<td>Labor and birth are managed as pathological conditions</td>
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<td>Interventions are used only when necessary</td>
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<td>Birth takes place within preference and needs of woman</td>
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<td>Birth takes place within preferences and policies of provider/institution</td>
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<td>Health focus is on emotional, mental, physical well-being</td>
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Women vs. The Medical Lobby

You may be surprised to learn that this constant tug-of-war over the options available to women is between families and the medical lobby. Yet, even as consumers beg for something different, the message they seem to keep getting is, “No—we know what’s best for you, and we’re it.”

Dozens of local and state consumer groups, as well as several national groups, are currently campaigning for more access to midwifery care. Certified professional midwives (CPMs) are legally allowed to practice in only 28 states; consumer groups in 14 other states are actively working towards state licensure for CPMs, a formidable battle for what are often young, cash-strapped families. Their chief opposition—doctors and the medical lobby—are the only group out there organized against access to midwifery, and they are a powerful, well-funded group. In Alabama and Massachusetts, for example, the only opposition to proposed bills by consumer organizations like the Alabama Birth Coalition and the Massachusetts Friends of Midwives is the state medical society and state ACOG representation.

Ethicist and obstetrician/gynecologist Paul Burcher acknowledged this influence recently saying, “Since obstetricians as a political lobby are largely responsible for these punitive laws, we should work to have them overturned if we seek to renew the trust of our midwife colleagues.”

Dr. Burcher is right. Even where midwifery is “legal” and licensed, it is frequently shaped by the political forces behind organized medicine. In other words, one profession is empowered by the state to police its competition. Its advice and permission are sought when the rules are made, and its presence—often a majority presence—is a given on the ruling bodies. What’s missing? The decisions of the women giving birth.
Before I end, I want to be clear about three things: One, I’m generalizing about entire professions, and I am deliberately highlighting the examples that prove my point. ACOG has produced some wonderful work like the “Safe Prevention” guidelines I mentioned earlier, or their amazing ethics guidelines. Obstetricians are a necessary and much-appreciated piece of the system, who are, moreover, under heavy pressures themselves. I work with some stellar ones who love and appreciate women and midwives. It is not every individual doctor, by any means, but the profession and its lobby that often acts as if the obstetrician in childbirth is there by right.

Two, there is no denying that American midwifery still needs developing, expanding and organizing, including protections for consumers. But I am continually surprised by assertions that midwifery should be more hobbled in order to achieve these goals. I don’t see any efforts to restrict the profession of obstetrics, despite the critical state of maternity care today and reports from consumers all over the country about mandatory surgery policies, coerced procedures, and abuse in hospital-based settings—with no meaningful protections for consumers in place there, either. In fact, I believe that doctors would be very resistant to the idea of an outside party levying such restrictions. No; for midwifery to reach its potential, midwives must be recognized as autonomous professionals—self-defined and self-regulated.

Three, I’ve never had a home birth and never will. This has nothing to do with my personal choices. What I see is that midwifery care is the Gold Standard the world over, and the less than 10 percent of U.S. women taking advantage of it is an artificially low number. That number represents not women’s best interests, but a conflict between what women need and what Big Medicine already has.

Stay in Your Lane, Brother

As long as we keep asking doctors if women should have midwives, the answer is always going to be the same: “Sometimes, as long as we’re supervising.” One of the reasons it’s so refreshing to see the new guidelines from the U.K. is because they demonstrate a measure of trust in women and midwives that does not exist in the U.S. The new guidelines say, “You ladies can handle this. And if it gets hairy, you know we’re here for you.” The American attitude is quite the opposite: “You can’t handle this, and we’re going to impose our help whether you want it or not.”

So why are we still asking doctors whether women can have midwives? Is it so hard to believe that women actually know what they need and want in childbirth? And that, for some of them,
midwife-led care might be it? Let’s please trust that women are capable of figuring out how, where and with whom to give birth. For those women who have the luxury of choice, they do not need to be told where to spend their maternity care dollars, nor do they deserve to have that money funneled into a system that doesn’t always fit them. For those women who are already limited in their choices, walling off an avenue for them to access compassionate, personalized, life-saving care is an egregious wrong. It is the human right of every woman to decide where, how and with whom she will give birth. Period.

Moving forward, we must affirm that collaboration and respect among healthcare professionals can only make American maternity care better. A recognition of the natural rights of women over childbirth can only make care better. If it is midwives who women identify as best fitting their needs, that should be the end of the conversation. There is no other permission to be sought.

This article appeared in Pathways to Family Wellness magazine, Issue #49.

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Why Are We Asking Doctors if Women Should Have Midwives?

Written by Cristen Pascucci
Tuesday, 01 March 2016 00:00 - Last Updated Friday, 15 September 2017 07:36

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