Letter from the Editor

Will Birth Attendants Need to Promote High-Tech Intervention to Afford Malpractice Insurance?

Abstract

In this column, the author examines the trends of the midwifery model of care versus nonmedically indicated cesarean births and their effect on malpractice insurance rates. Childbirth educators are encouraged to support a health-care system that promotes normal birth.

Journal of Perinatal Education, 13(1), iv–v; midwifery, normal birth, birth interventions, insurance.

In this issue of the *Journal of Perinatal Education* (JPE), we introduce a new column on teaching childbirth education headed up by Lamaze International President Barbara Hotelling. Members requested this column when they were asked what else they wanted to see added to JPE. Like all our JPE columnists, Barbara will appreciate reader input for her column. Although many JPE readers no doubt have invented or inherited teaching strategies worth passing on, not all have the time to put their ideas into publishable form. Now, through Barbara Hotelling, readers can send their ideas and watch them emerge as a publication. In this issue, Barbara's first column is especially appropriate given the following trends dominating childbirth.

The good news is that, in the United States, the number of births attended by certified midwives has moved from 7% in recent years to 10% this past year. Given the nature of the midwifery model of care, this trend suggests that more consumers are aware of the desirability of choosing a natural birth. (Some of these births occurred in publicly funded clinics and were not a matter of choice).

The bad news is that malpractice insurance for midwives has increased to the point that it causes long-established centers of midwifery care, both within hospitals and in birthing centers, to close down. Fees collected for practices that exclusively work with normal births may not cover the cost of the insurance. I believe many general-practice physicians who used to practice obstetrics have discontinued for the same reason.

Please correct me if I am wrong, but it seems a system is evolving wherein only care providers who carry out a significant number of high-cost birthing procedures can afford a practice of attending childbirth. Now, if you were to design a health-care system wherein only care providers who engage in a significant number of high-technological procedures could afford to practice obstetrics, what outcomes would you predict? Might you predict that the American College of Obstetricians and Gynecologists (ACOG) would pass a policy, as they have, supporting efforts to offer women a choice of nonmedically indicated cesarean births?

Would you guess that a percentage of ACOG providers will increasingly encourage nonmedically indicated cesarean birth, as they already do with the flimsiest of “medical indications”? Do you think the women choosing nonmedically indicated cesarean births are likely to be making an *informed* choice or do you think they will be frightened into surgery by the same forces that frighten many into planned epidural anesthesia? Who will introduce women to the potential of the Post-Ecstatic Birth Syndrome, a long-lasting, powerful surge of inner strength that often follows a well supported normal birth (Humenick, 2003)? And who would benefit most from such a system?

Approximately 25 years ago, I overheard one obstetrician brag, “Give us five years and we will make vaginal birth a thing of the past.” I was appalled then, as now. Since that time, I have watched with pleasure as the number of families choosing a midwifery model of care slowly but steadily increases. I applauded as the Lamaze International Board of Directors set the organization in a direction to work for normal birth. However, regardless of how we arrived at today’s trends, it seems clear that advocates of normal birth struggle against powerful economic forces. It makes me want to reread Lewis Carroll’s *Alice in Wonderland* and *Through the Looking Glass* to grasp what is happening. Without our continued effort, we might continue to drift towards a “system” where low-tech, low-cost childbirth is unaffordable while high-tech, expensive childbirth is the affordable norm.

Is there opportunity or only discouragement for Lamaze International advocates in these trends? Is the glass half empty or half full? The optimistic perspective would be that the pendulum has to swing rather far in one direction before it will begin a journey back in the other direction. Of course, the danger exists that the U.S. system of birthing will only get more and more out of balance. However, the hope also exists that, when a system reaches a certain degree of unbalance, it

too will begin to swing back. In that case, Lamaze International’s campaign to promote normal birth couldn’t be more timely.

—Sharron S. Humenick, RN, PhD, LCCE, FAAN

Reference

Humenick, S. H. (2003). Letter from the editor: Post-ecstatic birth syndrome. *Journal of Perinatal Education*, 12(1), iv-v.

Letter to the Editor

I am writing to inform you of what I hope is an isolated incident. I currently teach Lamaze at a Bay Area [California] hospital, but have been informed by letter that as of Jan. 1, 2004, this facility will no longer offer Lamaze classes.

In lieu of these classes, the obstetricians have put together a two-class series (3 hours each) that will cover general childbirth information as well as “specific information desired by the obstetricians.”

This health-care facility is state-of-the-art in many areas. In fact, just recently they opened a beautiful Lifestyle Rx building complete with therapy pool, family pool, gym, and exercise equipment. I was told on the tour that it was the only such facility affiliated with a hospital in the Bay Area or in Northern California.

In eliminating Lamaze, these physicians are severely limiting access to the wide range of information from which their clients can make informed decisions regarding labor and birth. Instead of serving their expectant clients with the highest quality of care, they are doing them a great disservice.

—Kathy Redmond RN, LCCE
California